South Carolina Department of Mental Health

Annual Report 1995-1996

DMH South Carolina Department of Mental Health

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Interim Director of Mental Health

MISSION STATEMENT
The men and women of the S. C. Department of Mental Health, in partnership with consumers, families and their diverse communities, will assist citizens with mental disorders to improve the quality of their lives.

Dear Friend of Mental Health:

This fiscal year has been one of steady progress on our goal of building a community-based system of care in South Carolina. We continue to respond to changes in the healthcare environment, and have devoted much time and energy to insuring that we have an organized system of care that can insure quality to our consumers and families well into the twenty-first century.

We continue to enjoy close, collaborative relationships with our sister agencies and braches of government, as well as with our consituency and advocacy groups.

This has been a year of transition for us, and it has been my distinct honor to serve as Interim State Director for this year. It is a tribute to the dedication of the DMH family that we have never waivered from our focus on delivering the best services possible to our fellow citizens with mental illnesses and their families.

I am confident that DMH will remain a leader in the behavioral health field in the years to come. I know that the members of the SC Mental Health Commission join me in extending gratitude to all who made this another successful year for DMH and the people we are privileged to serve.

John A. Morris, MSW
Interim State Director

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Overview

To provide mental health services to the citizens of South Carolina in an efficient and effective manner, the S.C. Department of Mental Health is divided into the Division of Clinical Services, five major administrative divisions and five offices as well as five special services divisions. (See SCDMH Organizational Chart, page 62).

The Division of Clinical Services has two major divisions—the Division of Community Mental Health Services and the Division of Inpatient Services.

Under the Division of Community Mental Health Services, the state is divided into 17 geographical areas called catchment or service areas, with a comprehensive mental health center located in each area.

Each center is governed by a local administrative board that operates within policies and guidelines set by the Department. These centers serve the state's 46 counties through main facilities and a network of clinics and outreach programs.

Nine major inpatient facilities compose the Division of Inpatient Services.

The community mental health centers serve as the entry point into the state's public mental health system. However, when a center's resources cannot meet a patient's needs, the center refers that patient to one of the Department's inpatient facilities.

The Department of Mental Health is governed by the seven members of the S.C. Mental Health Commission, who are appointed for five-year terms by the governor, with the advice and consent of the state Senate. They are: Mrs. Elizabeth L. Forrester, Chairman, Georgetown; Charles T. Battle, M.D., Vice-Chairman, Seneca; James E. Whitford, Sr., M.D., Goose Creek; Brenda H. Council, Orangeburg; Rhonda W. Baker, Simpsonville; Douglas F. Gay, Rock Hill; and Leon Finklin, Columbia.

S.C. Department of Mental Health
Mission Statement

OUR MISSION

The men and women of the S.C. Department of Mental Health, in partnership with consumers, families and their diverse communities, will assist citizens with mental disorders to improve the quality of their lives.

OUR PRIORITIES

The department will give priority to adults and children with serious mental illnesses and serious emotional disturbances and will fulfill its legislative mandates. We will work cooperatively with other agencies, both public and private, to assure continuity of services based on the needs of the individual.

OUR VALUES

Respect for the Individual

We believe that the people we serve have the right to personal dignity, respect and the highest possible degree of independence. We are committed to services that promote the individual's quality of life, focus on the individual's strengths, foster independence, and honor the rights, wishes and needs of the individual.

Support for Local Care

We believe that people are best served within their home community. We are committed to the availability of a full and flexible range of coordinated services with the community as the primary focus of care, and services that appropriately meet the needs of the individual in the most normal environment possible. We are committed to programs which build upon the local support provided by family, friends, other agencies and the community, and which offer employment, leisure, learning, residential and psychiatric/rehabilitation services within this supportive framework.

Professionalism and Commitment to Quality

We believe that we should encourage and reward excellence. We will create a work environment which inspires and promotes innovation and creativity, supports education and research, and continually seeks more efficient and effective ways to provide clinical and administrative services. We are committed to a skilled and ethical work force, culturally competent and dedicated to the highest standards of courtesy, understanding and respect. We will be an agency worthy of the highest level of public trust.

Major Accomplishments in Fiscal Year 1995-96

*** DMH Celebrates 175th Anniversary**

The year 1996 marked the 175th anniversary of the enactment of a Statute at Large to create a public institution to provide care and treatment for the citizens of South Carolina who have a mental illness. The enactment of that statute on Dec. 20, 1821, made South Carolina the second state in the nation to recognize the need for and provide funds for such an institution. The agency celebrated this milestone throughout the year with various projects, culminating with a Grand Celebration Dec. 20 at the Chapel of Hope on the S.C. State Hospital grounds.

*** Number of Clients Served**

In FY 95-96, the South Carolina Department of Mental Health served 82,651 clients in its 17 community mental health centers and 7,741 patients in its five psychiatric hospitals.

*** Toward Local Care Initiatives**

The Department takes the view that most people who have a serious mental illness do better clinically when treated in the community. People with mental illnesses need and require close family and community support. They get better faster and stay better longer when they receive services in their community, if these programs are reasonably funded, well organized, and easily available. To that end, through its Toward Local Care (TLC) and transition initiatives, the Department continued to focus efforts on delivering services to people with serious mental illnesses as close to home as possible, rather than disrupting their lives by sending them to large, central hospitals miles away from home.

In the beginning of FY 95, the third year of the TLC initiative, nine first-wave (TLC I) projects were already operational, and six second-wave (TLC II) projects were implemented during the last nine months of FY 95. The projects continued to provide a lower cost alternative to long-stay inpatient care. The TLC II projects served an average of 20.4 consumers at a total expenditure of $1,107,664.

*** Consolidation of Services**

The facilities comprising the Division of Psychiatric Rehabilitation Services (S.C. State Hospital and Crafts-Farrow State Hospital) continued to consolidate focusing on the integration of the two hospitals' cultures with the goal of taking the best from each facility. Patients and staff transferred from Crafts-Farrow to other facilities within the Department to avoid duplication of programs and to fully utilize resources. The consolidation resulted in an increase at S.C. State Hospital's patient census from 273 to 340 patients. For the first time since the mid-sixties, patients were not divided solely on age. The level of care, based on mental and physical needs, determined which patients would be assigned to S.C. State Hospital.

*** Services for the Deaf**

Services continue to be provided for several hundred people who are hard of hearing or deaf and who have a mental illness. One of this year's overwhelming successes was the implementation of a deaf telemedicine project involving three community mental health centers and a psychiatrist proficient in the use of American Sign Language. Through desktop computer systems set up in community mental health centers in Spartanburg, Greenville, and Lexington, clients communicate "face to face" with the psychiatrist in Charleston. For the first time in their lives, some of our deaf clients can actually talk directly to their doctor, without the aid of an interpreter.

*** Volunteer Contributions**

More than 10,000 volunteers gave 185,689 hours of service in mental health centers, hospitals, and community programs during FY 95-96. Contributions of such and materials totaled $1,914,177. The service value calculated for the volunteers' time added to the contributions brought the total value of the Community Resource Development Program to $3, 558, 661.

*** Budget**

Total expenditures for FY 95-96 were $301,500,919.

Major DMH Goals for FY 96-97

Major Goals for FY 1996-97 are to:

* continue to focus on providing quality mental health services in the least restrictive environment;

* implement a short-term and long-term strategy for movement toward managed care, advocating to become the managed care agent for behavioral health care for public funded citizens;

* develop standardized staffing patterns for all in-patient facilities;

* implement a standardized utilization management protocol for community mental health services;

* implement quality and outcome monitoring measures for specific categories of community services;

* help community mental health centers become accredited;

* continue implementing the Cutural Action Plan;

* continue working with community residential care facilities—implementing memoranda of agreement with all residential care facilities serving DMH clients and tracking clients in residential care facilities;

* increase consumer pre-vocational and employment opportunities; and

* continue offering more services to children, adolescents, and their families, increasing the number of staff providing school-based mental health services, implementing a program for transition-age youth who are aging out of child services, and expanding treatment for youths who are emotionally disturbed and are in the criminal justice system.

Division of Administrative Services

Administrative Support

The Division of Administrative Support is the component charged with the responsibility of providing consolidated administrative support to our inpatient and community treatment programs.

The division is comprised of four areas: Departmental Services—includes the departmental warehouse, consumable inventory, fixed assets, surplus property, and Physical Plant Services supply functions; Management Services—includes vehicle management, grounds maintenance, printing, microfilming, forms control, residential housing, vehicle and building insurance, and special projects; Nutritional Services— includes clinical nutritional services, food production, food delivery, and food serving; and Physical Plant Services—includes professional engineering, special and preventive maintenance, construction and renovation, building codes and licensing standards, energy use and conservation.

Departmental Service Operations are comprised of six sections—Warehouse, Fixed Assets, Forms Supply, Columbia Cluster Supply, Northeast Cluster Supply, and Inventory Control.

Responsibilities include not only ordering, stocking and issuing supplies, but also include technically supervising all mental health facility supply points and property control points for major movable equipment.

Some of our goals for FY 95-96 were:

* to get an on-line computer system for consumable supplies—we do not have an on-line computer system yet, but we still are hopeful of getting it. The Internal Audit Section has recommended that we get one, and the quality team that studied the supply system has also recommended this to DMH Quality Council. At this point, the Council has neither approved nor denied the system.

* to begin implementing a bar-coding system in the Fixed Assets Section—a bar-coding system has been bought and software is being changed so that it may be used. Implementation of bar-coding should begin by the middle of the fiscal year.

Columbia Cluster Supply and Northeast Cluster Supply now have the capability to use e-mail for receiving requests for supplies.

Departmental Service Operations has direct control over all stores that receive stock from vendors. Their activity for the year was as follows:

Store 00		Store 08	
Receipts	$ 3,080,468 46	Receipts	$ 346,307.14
Issues	$ 3,091,992.56	Issues	$ 318,181.29
# Units Issued	8, 458, 956	# Units Issued	20,818,992

Store 21		Store 22	
Receipts	$ 191,259.37	Receipts	$ 144,168.17
Issues	$ 172,148.91	Issues	$ 137,254.84
# Units Issued	2,555,690	# Units Issued	3,743,473

Disposal of Salvage/Surplus equipment and scrap amounted to:

DMH Bid Sales	$ 11, 337.10
Scrap Metal	$ 12.27
Scrap Grease/Fat	$ 109.51
DMH Net Proceeds	$ 11,458.88

State Surplus Sale of Surplus Vehicles:

Total Sales	$ 18,862.86
State Surplus Charges	$ 3,100.00
Paid to State General Fund	$ 7,881.45
DMH Net Proceeds	$ 7,881.41

State Surplus Sales of Surplus Equipment:

Total Sales	$ 20,388.41
State Surplus Charges	$ 6,777.00
Paid to State General Fund	$ 6,805.70
DMH Net Proceeds	$ 6,805.71
Disposal of Tires (pick-up)	$ 600.60

Goals for FY 96-97 are:

* to get an on-line computer system for consumable supplies;
* to complete implementation of a bar coding system in the Fixed Assets Section;
* to continue to streamline the ordering procedures in the Inventory Control Section for all our customers in facilities and centers; and
* to establish committees of our customers to evaluate new products and to write specifications for both new and existing items in stock—this will ensure that we have the quality products in supply that our customers need and want.

Management Services continued to support the facilities, centers, and other entities in their missions through the provision of quality services.

Each section met the goals it established and utilized the resources available in an effective and efficient manner. Management Services is a diverse component which includes Printing, Records Management, Forms Management, Vehicle Management and Grounds Maintenance. During the year, we added the Horticulture/Hortitherapy Program to provide patient activities and training programs.

Nutritional Services will start the Cook/Chill System in November 1996. The Cook/Chill system will meet the accreditation standards of all surveying agencies, offer flexibility in meeting the nutritional needs of the clients, and improve the work environment for the employees of Nutritional Services. The

mission for Nutritional Services is to provide total nutritional care.

The Cook/Chill system will improve the quality and choices of foods and will improve the nutritional care to our clients. The production and service process will be temperature controlled with an audit trail for monitoring any deviation problems.

During the FY 95-96, Nutritional Services performed an Annual Food Acceptance Survey; 90 percent of the items were nutritionally approved and will be added to the menu in FY 96-97.

The Quality of Work Life Committee has played a key role in improving the communication process and work place relations with the employees of Nutritional Services.

Nutritional Services observed National Healthcare Food Service Week in October 1995. All employees of the department were recognized and honored during this week.

Skill Enhancement classes were offered to all the employees of Nutritional Services. The program provided employees additional skills in reading, math calculations that relate to recipes, and stress management.

Other goals were met by providing seasonal meals with holiday themes and seasonal tray favors. Other menu items were added during the year to provide total patient care.

In conclusion, the Cook/Chill System will provide our clients a greater variety of menu items to meet their nutritional needs on a daily basis. Nutritional Services will continue on a daily basis to meet our mission which is to provide optimal nutritional care.

Goals for FY 95-96 are to:

* continue to provide optimal nutritional care for our clients;
* improve the employee working conditions and job satisfaction through the Quality of Work Life Committee;
* implement new budgetary controls and reduce labor cost; and
* develop and implement a dysphasia menu.

Physical Plant Services staff are occupied with the management of various projects and Department and centers capital development plans. Examples are: assistance in architectural selection, land selection, negotiating the project through the various steps that are required by the Budget and Control Board, and generally managing the projects until completion.

In the Northeast sector, Tri-County's Dillon satellite is currently under construction, and Pee Dee Mental Health Center (Lake City Satellite) is under construction.

In the Lowcountry, centers completed were Coastal Empire Mental Health Center and satellites in Coastal's five county service area. Allendale, Hampton, Colleton, Jasper, and Hilton Head satellites are currently occupied and serving clients. Charleston-Dorchester Mental Health Center is serving clients in their Dorchester satellite and has selected a site in Charleston for a main office. Santee-Wateree Mental health Center completed the construction of a satellite in Manning. Orangeburg Mental Health Center is contracting for construction

for their new main office in Orangeburg and two of three planned satellites in their service areas, Denmark and Holly Hill, are currently occupied and serving clients. The third satellite in their area, a Calhoun County clinic in St. Matthews, is in the bid phase for construction.

In the Upstate region, Beckman Mental Health Center completed a Laurens satellite and has identified land for a Newberry Satellite. Spartanburg Mental Health has identified a site for their facility, and has the selection process underway. Catawba Mental Health Center has purchased a site for a new Lancaster Satellite and construction in underway. Piedmont Mental Health Center has acquired land, and design is almost complete for a new facility in Simpsonville.

In the Midlands, Lexington Mental Health Center purchased land for an office in its service area and is planning a main center adjacent on the site. Also, Columbia Area Mental Health Center has an ongoing renovation of their Independence House on Carter Street and has an administrative office building ready for construction on the same campus.

On the Central Campus, Physical Plant Services Maintenance staff has been diligent and dedicated to providing quality service.

Physical Plant Services' goals for the coming fiscal year are the timely completion of the above projects and continued quality and preventive maintenance to buildings and systems in our charge.

Children, Adolescents, and Their Families

The vision of the Division of Children, Adolescents, and Their Families (CAF) remains to develop a statewide system of mental health services to address the various needs of our state's children, adolescents, and their families experiencing emotional, behavioral, and psychiatric disorders. This vision is built upon the premise that a broad array of services must be made available which are child-centered, family focused, community based, and culturally competent.

Once this system has been developed, every effort must be made to infuse the various elements of that system into all existing and future child serving systems (e.g. juvenile justice, education, child welfare, etc.).

Stated another way, if children and their families are unwilling to come to us, then we must employ strategies which allow us to take our services to the children and families of South Carolina who will benefit from our care.

The following are a few of the major accomplishments during FY 95-96:

* The Village Project, funded through the Bureau of Children, Adolescents, and Their Families within the Substance Abuse and Mental Health Administration, continues to receive national recognition.

* Various evaluators and consultants from around the country as part of the nationally funded evaluation of these demonstration projects have given The Village the highest marks and lavished upon its numerous accolades.

* The success of The Village resulted in receiving a supplementary grant specifically to develop services for children zero to five. With only two years remaining on the grant, the primary focus is to decide upon which elements of

The Village should be replicated across the entire state, which would have the greatest impact upon enhancing the overall service system for children, adolescents, and their families.

* There was a 22 percent increase in the total number of children served through our community mental health centers and hospitals—specifically, FY 94 saw 21,245 children, adolescents, and their families served, while FY 95 saw 27,157.

* With the emphasis upon community-based services, the centers' children/families served increased from 20,519 in FY 94 to 26,419 in FY 95.

* In the area of human resource development, FY 95-96 saw an increase of 23 percent in the total number of child mental health professionals employed through the community mental health centers.

* During FY 95, there was a total of 311, while during FY 96 the number increased to 399.

* Of particular note is that more than 27 percent of the current child mental health work force consists of professionals of color, with the dominant group being African-American.

* At the end of FY 95, there was a total of 63 child mental health professionals working within a total of 119 schools — at the end of FY 96 there was a total of 96 child mental health professionals working in a total of 161 schools — a 54 percent increase in one year alone in the number of child mental health professionals working within schools.

During FY 96, DMH received a three-year grant from the Federal Department of Health and Human Services Maternal Child Health Bureau Adolescent Branch to coordinate health and mental health services to students with emotional problems at the state level and at two South Carolina school districts (Lexington and Hampton counties).

Local project coordinators have been hired in both districts to assess the students' health and mental health needs and help students receive these services.

This project involved hiring six student interns from Benedict College, an historically African-American college in Columbia, to work with students in the two school districts.

This project, given the needs of the two school districts chosen and our first formal training relationship with an historically Black college and university, has received positive evaluations on the federal level and a request to have information about the project presented at national meetings.

Services for children between ages zero to three remain a priority within the Department. This federal initiative, referred to as BabyNet within South Carolina, once again expanded within the Department—an increase from six to eight BabyNet child mental health professionals. In addition, pilot projects were implemented in Dorchester and Santee-Wateree, called Mental Health Round Tables. These projects are developed to staff problematic cases from a mental health perspective.

With the ending of the Child and Adolescent Service System Program

(CASSP) Grant, the Department continues its commitment to the training of child mental health professionals. To this end, $100,000 was made available to Hall Psychiatric Institute to continue the training of child mental health professionals from the community mental health centers.

The Institute hired a coordinator for this initiative, and plans are underway for the Institute to assume responsibility for this important initiative. A minimum of 34 professionals will be trained per year.

The Department also remains committed to the continued development of its Family Support Network. Here again, with the conclusion of the CASSP Grant, the Department has made available funds to continue this initiative.

These funds have helped maintain 20 parent support groups across the state and trained 13 additional parents to facilitate more parent support groups around the state.

Efforts were begun to develop a request for proposal (RFP) to ensure the continuation of the Family Support Network under the auspices of a not-for-profit entity within the state. Thirteen parents were trained.

A major mail out effort was initiated to increase the pool of trained child mental health professionals available to the Department's community mental health centers.

With assistance from Human Resource Services, a DMH package was developed for 60 graduate programs offering degrees in psychology, social work, counseling, and marriage and family therapy. This effort will continue at least twice a year with plans to reinstate campus visits during FY 97.

DMH, through its community mental health services, participated in the statewide Interagency System for Caring for Emotionally Disturbed Children initiative. This initiative focused on children who were wards of the state and thought to be in need of out-of-home clinical care.

More than 1,800 cases were staffed, with DMH child mental health personnel involved in the vast majority of them.

DMH continues to work closely with the Department of Juvenile Justice around its federal overcrowding lawsuit. During FY 96, the outpatient program, under the auspices of Hall Institute, moved to Unit 180 and became a residential treatment facility.

At the same time, two beds were set aside for females in Directions, a Hall Institute residential treatment facility. At the same time, two RFPs were developed and released for a 20-bed residential program for very aggressive and violent youth and a second 20-bed residential program for sexual offenders.

During this period the Department was not involved in the clinical placement of children out-of-state for the first time in years.

A significant issue yet to be addressed is the development of residential and community-based services for young adults.

A completely different age, clinical, educational/vocational, and social array of services must be developed for young people between the ages of 16 and 24. This multiple aged, multiple need service must become a priority for the Department.

Consumer Affairs

The Department's Office of Consumer Affairs collaborated this year with the Department divisions of TQM and Quality Improvement and Advocacy to develop a pilot project to measure customer satisfaction levels of service recipients. Funding for the project was awarded by the Budget and Control Board, and research will begin in the new fiscal year.

After conducting several Consumer/Physician Roundtables with DMH general counsel, Consumer Affairs submitted a prototype of an Advanced Psychiatric Directive for management approval.

The monthly training meetings of Consumer Affairs coordinators at our 17 mental health centers have expanded to include the first in-patient consumer affairs coordinator at Morris Village.

And, last, the consumer-driven *Palmetto Pride Retreat* received 100 percent positive evaluations by consumers and staff alike as a worthwhile experiment in alternative treatment settings and sensitivity cross-training.

Elderly/Long Term Care

DMH has again sponsored a very successful Geriatric Specialist Basic Course at the 1996 Governor's Summer School of Gerontology at Winthrop University.

Of the 33 participants attending, 27 were drawn from mental health centers and facilities. The remaining number came from other state agencies.

The primary goal of this 30-hour classroom course is to provide professional education and leadership to staff members who are involved in the provision of services to elderly citizens and caregiver family members.

An outstanding product of this year's class was a significant number of work site related programs designed throughout the week. These programs can then be implemented upon return home to facility and center. DMH scholarships were used to cover the cost of the course and as a positive encouragement to attract appropriate staff.

The course was conducted by six mental health professionals and a private practice pharmacist from the community. Additionally, an Advanced Course in Geriatric Specialty was offered in September of 1995 at William S. Hall Psychiatric Institute. Ms. Carol Ann Beard was instrumental in the planning and implementation of the Advanced Course.

The Special Division for Elderly/Long Term Care continues to provide significant public awareness of elderly issues through the use of conference presentations. Several highlights for this period include special presentations made at the Catawba Mental Health Center Annual Elderly Conference, the Low Country Alzheimer Chapter Conference, and the Joint Legislative Committee on Aging. Presentations at these events were supplemented with a number of presentations at social and fraternal clubs such as Sertoma and Lions Club.

Interagency cooperation and program planning continues to be a significant responsibility for this division. Activities with the Governor's Division on Aging

include well known events such as the Gerontology Summer School, Aging Successfully Conference, and the Alzheimer's Advisory Council.

The Advisory Council is a 17-member body created by the Legislature in April 1994. The purpose of the Council is to provide statewide Alzheimer activity coordination, leadership, collaboration, and technical assistance to both public and private agencies as well as to provide significant information and referral services to caregiver family members.

The primary activity with South Carolina Health and Human Services involves a large number of activities around the Primary Prevention Institute with a focal point of local community training throughout the year and an annual conference to be conducted this year in October at the Adams Mark Hotel.

Additionally, there continues to be considerable interest in developing standards appropriate to services for the field. DHEC activities during the time period have involved presentations to home health nurses and involvement in the residential care standards development for elderly housing and care. Involvement with DSS continues to focus on elder abuse and neglect issues as well as placement of difficult cases.

Developmental Disability and Special Needs activities center around assessment and placement of mentally ill and mentally retarded persons. There is a significant need here for both cross training and interagency staffing on unusual cases.

Two recent hurricanes, including Hurricane Fran, created a large number of activities with the State Emergency Operation Center (EOC). This involved coordination and planning with DMH Public Safety around the proper response of DMH to local needs for emergency response teams.

Activities within the state EOC are coupled with high levels of communication with local centers and facilities particularly around bed availability and the formulation of crisis response teams to service the areas behind the storms.

Services to family members and caregivers center upon consultation and assistance in acquiring information concerning placement opportunities, caregiver training, proper referral to coordinating agencies, home safety issues, and the aging process. A first priority with this process is that of trying to maintain an individual in the home with quality care. Not only does this strengthen the relationship with family members, but it also relieves pressure upon DMH facilities for admission.

Inpatient Services within DMH continues to evolve as needs change. As of September 23, 1996, Bryan Psychiatric Hospital began admitting geriatric patients who historically have gone to Crafts-Farrow State Hospital. Additionally, Harris Hospital is in the process of opening a gero-psychiatric unit. Byrnes Medical Center may continue a specialized program to be considered after further study of the issue is completed.

One interesting note is that facilities are sharing expertise and experience through the change of staff presentations and policies and procedures.

DMH has also consolidated its Pharmacy Consultation service to mental health centers and facilities through the mechanism of identifying a commu-

nity pharmacy consultant. Staff responsibility includes on-site inspections, consultation, medication education, and continued development of system-wide policies and procedures.

Staff continue to provide consultation on individual client needs to the different mental health centers, Disability and Special Needs boards, DMH inpatient facilities, and Disabilities and Special Needs regional centers and are involved in numerous interagency staffing to establish treatment plans for individuals who require services from both DMH and DDSN.

During this time, Mr. Bruce Cannon presented a paper at the National Association for Dually Diagnosed in Orlando, Florida, in November 1995.

Services for the hard of hearing/deaf continue to be provided for several hundred mentally ill deaf persons within the state. One of this year's accomplishments was the implementation of a deaf telemedicine project involving three mental health centers and a specially trained psychiatrist.

Drs. Barry Critchfield and Jill Afrin, a psychiatrist in Charleston, have made a total of five national presentations on this project to date. Additionally, Mr. Ed Spencer will present this service to the Elderly Division of National Association of Mental Health Program Directors in Austin, Texas, in October 1996.

Financial Services

The Patients' Personal Affairs Medicaid Outreach Program continues to maximize Medicaid revenue for inpatient children's services and the Children's Residential Treatment Facility and has expanded to Tucker/IMD.

Medicaid billing for children's services has moved to the electronic UB92 system, which allows more timely payment of claims and prevents the paperwork requirement for current eligibles.

Work continues toward more automation of activities to improve timeliness, where possible, in establishing patients' eligibility for benefits.

The community mental health center "Entitlement Specialist" program continues to increase the number of Medicaid-eligible clients served and to increase the amount of Medicaid reimbursement received by the Department.

Patients' Personal Affairs (PPA) staff continue to provide to inpatient facilities technical assistance, i.e., training on eligibility criteria for Medicaid, Social Security, Supplemental Security Income, etc., as well as individual case consultation.

The staff provides this same technical assistance to the community mental health centers and inpatient facilities in order to secure maximum benefits for patients who are to be placed in the community.

The Social Security Administration conducted an on-site review and found no difficulties.

PPA's Reimbursement Section's major objective is to maximize collections from third party payers for inpatient care.

Goals for FY 96-97 include automation of additional reimbursement processes and the identification of new programs to increase revenue.

A program that has recently begun is the billing to Medicare for parenteral

and enteral feedings. This will reimburse the Department for costs that have been previously lost.

During FY 95-96, the Cost Development Section of the Division of Financial Services (DOFS) successfully prepared and filed electronically 20 federally mandated home office and inpatient hospital cost reports. Eight of these were Medicare, and 12 were Medicaid. All of these reports were submitted before their respective deadlines and justified over $47 million in federal inpatient revenue to DMH for the year.

Also during the past year, the DMH/CMHS Rate Justification Study [formerly prepared by the Division of Information Resource Management's (DIRM) Patient Data Reports (PDR) Section] was completed by Cost Development and submitted to Health and Human Services Finance Commission. This report is used to support an additional $41 million in Medicaid outpatient revenue received by DMH's community mental health services annually.

In FY 96-97, Cost Development will continue its endeavor to maintain the timeliness, increase the accuracy, and improve the efficiency of its accounting procedures.

The Accounting section has been involved in several projects to strengthen internal controls and improve data transmission to the Comptroller General's Office during FY 95-96. Transactions from local composite bank accounts have been incorporated into the agency's financial records; revised procedures for payment of tuition reimbursements for associate degree nursing students have been developed, and a new system to allow Payroll to input manually submitted payroll data corrections to the Comptroller General's Office has been implemented.

Projects for FY 96-97 will include a major revision to the Agency's Chart of Accounts that will improve centers' and facilities' abilities to track their expenditures and a financial data base that can be accessed by users.

The Procurement office is in the middle of many changes. Based on audit recommendations, the Department will curtail the use of the F-11A as a direct procurement tool. An F-14 form has been introduced for direct purchases made by certified personnel. Training sessions have been held for all areas of the state, and Procurement continues to work with all concerned while areas are all in the learning process. These changes should greatly improve internal controls in the Procurement area.

The Contract section, working in cooperation with the Nurse Executive Council and the State Procurement Office, developed a Qualified Provider List for supplemental nursing staff contractors.

The QPL replaces the numerous individual contracts which were required of each DMH facility and establishes uniform rates and service provisions.

Also, in cooperation with State Procurement, the Contracts section participated in a complex multi-agency Request for Proposals to establish contracts for children's services such as therapeutic foster care, respite, supervised independent living, and high and moderate management group homes. When the process is completed, approximately 80 service providers will be available for

use by staff at the various agencies that serve children and adolescents.

During FY 95-96, the Contracts section worked closely with Computer Services on its new contract database. The database, which will provide enhanced information on the Department's contracts and leases, will be in use early in FY 96-97.

The Policies and Procedures section has issued 12 of the 14 sections of the Division of Financial Services (DoFS) Policies and Procedures Manual. Within each section are individual policies and procedures addressing subjects related to the section. The remaining two sections are being finalized. Numerous revisions have been issued to modify policies and procedures as changes in financial regulations, requirements and/or processes occurred.

All DoFS directives which contained primarily general policies have been incorporated into and replaced with more defined policies and specific procedures of the manual. Consequently, all financial directives (approximately 18) have been canceled.

The Policies and Procedures section continued training initiatives and performed compliance reviews primarily on Payroll and Time keeping operations.

General Counsel

The Office of General Counsel provided legal advice on a broad spectrum of issues during the past fiscal year, including almost all of the State Plan goals.

Several attorneys participated in training on managed care issues and worked with DMH divisions on its Organized System of Care. While continuing to review and approve hundreds of Department contracts, staff counsel also participated in the groups which developed streamlined contract approval processes and improved contract monitoring procedures.

With the Office of Consumer Affairs, the Office of General Counsel participated in consumer roundtable discussions on advance directives for psychiatric care. These roundtables resulted in a proposed DMH directive which includes a document that can be used for expressing an individual's desires concerning psychiatric treatment.

Over 30 presentations were made to groups in the Department and in the community on issues with legal components.

The Office of General Counsel was involved in the development of the Department's response to the report of the Legislative Audit Council.

The Office of General Counsel will work with other divisions of the Department on implementation of many of the Department's FY 96-97 goals, such as streamlining operations and support for local care, implementing the Cultural Action Plan, increasing consumer employment opportunities, continuing joint initiatives with the Department of Juvenile Justice, and continuing to improve utilization of Department inpatient facilities.

Human Resource Services

In FY 95-96, the Division of Human Resource Services accomplished the following:

* implemented a new classification and compensation system in July 1996;

* approved a new hire rate to bring LPN pay up to a more equitable level;

* drafted written procedures for dual employment;

* implemented a computerized insurance reconciliation that is being balanced on a monthly basis;

* began conducting onsite investigations to determine the cause of injury to our employees;

* implemented improved sign-out system that has increased efficiency and decreased retrieval time for requests for personal folders;

* streamlined and decentralized the hiring process with all major decisions now being made at the center level;

* developed a comprehensive Employee Assistance Program (EAP) manual;

* gave an all-night series of workshops at State Hospital on utilizing EAP services;

* identified key EAP contact persons in each center, which will greatly enhance the working relationship between EAP and the centers;

* developed, printed and distributed an "Employee Satisfaction Initiatives" booklet describing innovative programs developed within the Department's hospitals, centers, and the S.C. Public-Academic Mental Health Consortium;

* developed an Employee Ethics Statement by the Employee Satisfaction and Productivity Committee of the S.C. Public-Academic Mental Health Consortium and was approved by the Mental Health Commission;

*identified through the S.C. Public-Academic Mental Health Consortium the work force needs of the Department for people working with adults with serious and persistent mental illnesses. This report identified the knowledge, skills and attitudes needed to successfully provide services in the local communities and developed innovative approaches to providing these services;

* sponsored Research Connection 1996: "Outcome Measures: Preparing for Managed Care" and published proceedings by the S.C. Public-Academic Mental Health Consortium;

* sponsored on behalf of the Southern HRD Consortium for Mental Health a National African-American Clinical Training Conference in Atlanta Sept. 6-8, 1996, for 250 professionals. This conference was organized to encourage traditionally black colleges and universities to develop new or improve existing clinical training programs in disciplinary areas relevant to public mental health. The conference was funded by a contract from the Center for Mental Health Services; and

* the Southern HRD Consortium is replicating the South Carolina Title II Americans with Disabilities Act Project in three Consortium states (Arkansas, Mississippi, and Oklahoma). Funding for this project is through a contract with the Center for Mental Health Services Protection and Advocacy Program.

Major goals for FY 96-97 are to:

* implement new policies required for the new compensation system;

* review all agency internal titles;

* clear up all outstanding insurance balances that have resulted from over-

payment or underpayment with investigation and follow-up;

* evaluate an imaging system for use in the Records section to further increase efficiency and accuracy in record keeping;

* analyze information in order to recommend programs to reduce our workers' compensation premium;

* continue with case medical management and look into utilizing managed care providers in order to further reduce workers' compensation costs;

* include the facilities and divisions in the decentralized hiring process. Provide extensive training to staff to accomplish transition. Evaluate effectiveness of new process;

* develop and provide agency-wide training on revised EPMS procedures;

* review all HRS policies and make revisions in accordance with current regulations, laws and practice;

* expand EAP's list of providers so that each catchment area is adequately covered;

* provide supervisory training pertaining to utilization of EAP services in mental health centers which seldom utilize these services.

In addition:

* the Employee Satisfaction and Productivity Committee of the S.C. Public Academic Mental Health Consortium will move toward making the Ethics Statement a "living code of conduct";

* the S.C. Public-Academic Mental Health Consortium will complete work force plans describing knowledge, skills and attitudes needed by staff working with persons with dual disorders (mental illness and substance abuse), with children, adolescents and their families, and with elderly individuals and their families;

* S.C. Public-Academic Mental Health Consortium will assist the Department in its implementation or Work force Plans for adults with serious and persistent mental illnesses and other plans as completed;

* S.C. Public-Academic Mental Health Consortium will sponsor Research Connection 1997: "Consumer Issues in a Managed Care Environment";

* the Southern HRD Consortium for Mental Health will sponsor a planning conference for a second National African-American Clinical Training Conference, funded by a contract from the Center for Mental Health Services; and

* the Southern HRD Consortium for Mental Health will complete and evaluate the ADA Title II Replication Project being conducted in Arkansas, Mississippi and Oklahoma. Funding for this project is through a contract with the Center for Mental Health Services Protection and Advocacy Program.

Public Safety

During the past year, this division has been involved in a large project to consolidate a number of organizational components in one building to improve overall efficiency and better utilize our personnel and resources. The final phase of this project includes the centralization of radio communications and fire alarm systems for DMH facilities located in the greater Columbia area.

This division continues to provide a safe and secure environment for clients, employees , and visitors through the enforcement of state laws and DMH policies and procedures. During the past year, our staff investigated over 600 cases and recovered stolen goods and property valued in excess of $25,000.

Quality Improvement/Advocacy

The Office of Quality Improvement/Advocacy continues to provide support for the agency's quality initiatives. During this past year, the adequacy of quality improvement teams' reports has improved and has clarified the purpose, actions taken to improve care, and outcomes of the quality initiatives.

The office has implemented a process that provides assistance to facilities and centers in credentialing physicians and responses to accreditation requirements. The credentialing services include checks with the National Practitioners Data Base and the American Medical Association Physician Profile Service in support of privileging decisions regarding services to patients.

A major new assignment of the office is to provide leadership for the Organized System of Care (Managed Care) that the Department of Mental Health has initiated. The Organized System of Care focuses on 18 elements necessary to position the agency for success in the mental health care market of the future.

The rapid development of some selected parts of health care reform is already being fielded by the Department. It is the goal of the Organized System of Care to place consumer care issues and quality first as we move toward an emerging reformed behavioral health care market.

Community Residential Care Facilities—During FY 96, the State Planning Council's goals for improving the quality of life in community residential care facilities were addressed. Specifically, in October 1995, the Community Residential Care Facility (CRCF) System, which was developed to provide the Department with an inventory of the CRCFs utilized by clients served by the community mental health centers and the clients living in each home, was piloted by the Charleston/Dorchester Community Mental Health Center.

In November, liaisons from each center, Bryan Psychiatric Hospital, Morris Village, and State Hospital received training on the CRCF System.

Subsequently, client-specific data was entered and all CRCF data was updated. With the exception of Patrick B. Harris Psychiatric Hospital, the CRCF System is now accessible to and utilized by staff in all centers and inpatient units. It is anticipated that Harris Hospital will have access to the system by the end of the calendar year.

In February 1996, the community mental health centers began entering into Memorandums of Agreement (MOAs) with the CRCFs in their catchment area, which agree to provide additional services under the terms of the MOA.

With the exception of one center, all community mental health centers have completed implementation. These 16 centers utilize 283 CRCFs in the state, and they have entered into MOAs with 73 percent of these community residential care facilities.

In the remaining 76 cases, 64 CRCF operators did not sign the MOAs because they did not agree with the CRCF responsibilities outlined. Twelve CRCFs were not offered an MOA by the center because of the quality of care and treatment provided to residents, noncompliance with DHEC regulations/standards, and/or the working relationship between the center and the CRCF.

In conjunction with the MOA implementation, a directive regarding discharging clients to CRCFs was developed. The directive (#797-96) essentially states that the Department will make every reasonable effort to recommend and assist in a client admission only to a CRCF that has signed an MOA with the local community mental health center.

Finally, to learn more about what other states were doing to measure and monitor quality of life issues in community residential care facilities, in February 1996 a mail survey, *Monitoring the Quality of Life,* was circulated to the 55 state government mental health programs. Prior to circulation, the survey was reviewed by the State Planning Council's Subcommittee on CRCFs and the National Association of State Mental Health Program Directors. Over two-thirds (71 percent) of the 55 mental health programs responded to the survey.

A report, *Monitoring the Quality of Life in Community Residential Care Facilities: A Survey of State Government Mental Health Programs,* summarizing the information was distributed in October.

Division of Community Mental Health Services

Aiken-Barnwell Mental Health Center
(Aiken and Barnwell counties)

During FY 96, all necessary approvals were obtained to begin construction of a new central facility in Aiken. Construction activities have already begun, with work to be completed by May 1997.

The building will be 27,000 square feet and will encompass programs currently housed in five separate locations in the Aiken area.

Our North Augusta office moved into a larger rented facility in January 1996, providing sufficient space for staff to overcome the previous problem of overcrowding.

A dually-diagnosed (substance abuse) treatment group was begun in September 1995 and is still operating. However, this is not adequate to deal effectively with the extent of the problem of substance abuse among our seriously mentally ill clients, and, therefore, additional steps need to be developed with the collaboration and assistance of our local commissions on Alcohol and Substance Abuse.

The center's management continued to focus on developing managed care principles within its operations. In addition to implementing rapid access to all its services, management monitoring reports have been revised to provide more detailed clinical and financial data, which have now been made available in a more timely manner (weekly and monthly). This data is then used as appropri-

ate in management decision-making.

Staff productivity rates have been increased, and some restructuring of programs has occurred to improve cost efficiencies. Planning is already under way to implement Utilization Management in FY 97 and to seek CARF accreditation. All of this has been accomplished with tremendous stress and effort and much overload on the part of staff.

In addition, since so much attention has to be continually focused on cost efficiencies, a Budget and Expenditure Committee composed of mid-management staff was established in September 1995 to review financial data, determine additional information needed for sound financial decisions, and make recommendations to upper management as to revenue enhancement or cost efficiencies that may be needed. It has proven to be very useful. Also, the process of making revenue and expenditure projections was revised to improve its accuracy.

As a result, the center was able to sharply reduce the significant deficit with which it entered FY 96. This remaining deficit balance will be carried forward into FY 97 and eliminated in FY 97.

During FY 96, a partial hiring freeze was continued from the previous year in order to reduce the center's deficit. The average number of staff at the center in FY 96 was 82.6, down from 90.7 in FY 95, a decrease of 9 percent.

Total number of staff on 6/30/96 was 79 compared to 86 on 6/30/95, a decrease of 7. One of our four psychiatrists resigned to work out of state. There was a 16 percent decrease in clinical staff (10) over the year as the center strove to cut costs while at the same time increasing the productivity rate of its clinicians. There was a 22 percent increase in administrative support staff (4), as clerical workers were moved from long-term temporary positions into permanent full-time positions in order to further strengthen operational support activities.

It now is evident that in FY 97, some of the current vacant positions need to be filled for use in underserved clinical program areas.

In FY 96, there was a total of 3,811 persons who received treatment services from the center. There was a monthly average of 1,290 clients treated (a 7.5 percent increase over FY 95); and a total of 61,930 client contacts for the year (a decrease of 1.3 percent).

Given the 10 percent overall reduction in clinical staff during this year, this data demonstrates a very remarkable increase in staff productivity during the year and gives greater understanding to the very great stress staff have had to endure to achieve this increase in productivity.

State psychiatric hospital admissions rate for ABMHC rose from 142.0 per 100,000 population in June 1995 to 170.2 per 100,000 population in May, 1996 (latest data available). The re-admission rate, however, rose slightly from 48.2 percent in June 1995 to 49.4 percent in March 1996.

It is not clear yet why there is an increasing number of first time admissions to the state psychiatric hospitals, although an estimated 60 percent of those being sent to the psychiatric hospitals have a substance abuse disorder.

The center is currently working with the local emergency room physicians and the Aiken Center for Alcohol and Drug Services to find more effective ways to deal with this problem of increasing hospital admissions.

Goals for FY 96-97 are to:

* eliminate the center's budget deficit by June 1997;

* reduce admissions to state psychiatric facilities down to a rate of 140 per 100,000 general population;

* increase level of services for dually-diagnosed substance abuse clients;

* continue implementing managed-care principles into the center's operations, especially a process of Utilization Management; and

* take preparatory steps to meet CARF accreditation standards, so that an application for CARF accreditation can be submitted in June 1997.

Anderson-Oconee-Pickens Community Mental Health Center (Anderson, Oconee, and Pickens counties)

The center's catchment area continues to grow to over 327,000 citizens. Its counties are comprised of a great diversity of industry, technology, and expanding housing opportunities. The area is roughly mid-point between Atlanta and Charlotte on Interstate 85. People locate in the area for recreation, retirement, educational, and business opportunities.

The center works closely with Patrick B. Harris Psychiatric Hospital, which is in its catchment area, and the other Region B mental health centers in the upstate.

The center, through a contractual agreement, has 44 consumers housed at its Village Residential Care Facility. It also has 12 chronically mentally ill persons living semi-independently on the Village campus. The Brookway Residential Care Facility in Easley has 26 residents. Another 94 clients reside in local care facilities with whom there is a cooperative, working relationship to make possible successful community living.

In order to support persons who need transitional skills, five-day programs are operated over the three-county area to teach living skills and other psychosocial skills. Additionally, a Saturday programming is available to patients who require the support.

A Toward Local Care (TLC) team operates seven days per week to care for those 10 seriously mentally ill clients who were relocated to the area with grant assistance.

To meet acute or crisis needs, the center maintains three after-hour crisis intervention units. These units, with a staff person at the Anderson Area Medical Center's Emergency Room, from 5 p.m. to 12 a.m. each evening, screen people in need of assessment for hospitalization or referral to less intense treatment modalities.

By lease agreement, the center has secured adequate quarters for its program and staff for the present. It operates a large fleet of vans and cars to assist consumers who require transportation to avail themselves of mental health services.

The first goal of FY 95-96 was to balance the budget. This was an awesome task given a projected deficit of some $750,000.

To accomplish this objective, the center left unfilled numerous positions, cut travel, and minimized all expenditures possible. With fewer staff, the center produced and billed for record services, overcoming the deficit and beginning the new year in sound financial status.

In spite of its efforts, the center has been unable to reduce its admissions to state psychiatric facilities. While there are many unique reasons why this goal has not been met, staff will focus on accomplishing this task in the new year.

There has been excellent cooperation with Region B initiatives. This creative endeavor will be continued as many of these objectives are reflected in statewide efforts to be more efficient, effective, and to increase consumer satisfaction.

Volunteer services have not only expanded, but have been integrated through our system of care. Individuals and groups who have given of their time and abilities have become indispensable both to consumers and staff.

The active caseload, at over 4,600 clients, has been among the highest in the state. The center's staff has been commended for their work as productivity has risen with astonishingly high caseloads.

The center, being among the lowest in funding per capita, was awarded $730,000 new dollars to expand services to its constituency.

With increased funding, the following goals were established for FY 96-97:

* to create a non-medical crisis stabilization unit to reduce hospital admissions;

* to increase case managers in Anderson County by five and C & A staff by three, a full-time school-based counselor to District #2 schools and additional clinical and support persons, for a total of 17;

*to hire an additional physician in Oconee County to give 11/2 full-time employee psychiatric coverage to the clinic; add two case managers and one child and adolescent therapist; with additional clinical and administrative support, the total of new staff will be 51/2.

* to increase medical coverage in Pickens County to 11/2 full-time employee psychiatric coverage; two case managers will be added and one child and adolescent staff which, along with other clinical and administrative support, totals 51/2 new full-time employees;

* to be CARF accredited with a survey in June 1997;

* to finish the year with a balanced budget;

* to lease new space for crisis stabilization and offices to accommodate additional staff and new programming;

* to cooperate with groups providing PEP services or other Primary Care providers with whom it establishes a cooperative relationship;

* to increase through computer, telephone, and other technical equipment available, accurate and timely data for the provision of clinical services at various locations across the catchment area;

* to increase staff accountability for their productivity and quality of work

including consumer satisfaction; and

* to support the local Mental Health Association's efforts to build 18 new housing units for the chronically mentally ill.

Beckman Center for Mental Health Services (Greenwood, McCormick, Saluda, Edgefield, Laurens, Abbeville, and Newberry counties)

FY 95-96 brought continuation of the center's evolutionary process. New management and leadership climate fostered program growth and development under protocol of the center mission statement. The Beckman Center for Mental Health Services, with its geographically challenging seven-county catchment area, remains ever more committed to continuous quality improvement in all phases of mental health service delivery.

With the mission statement clearly in view, the center provided priority care to adults with severe and persistent mental illness, severely emotionally disturbed children and their families, and others as resources allowed.

During FY 95-96, a combined total of 7,585 consumers were served through 94,241 total contacts. A total of 2,942 new cases were opened (1,030 age 17 and under), while 2,830 (937 age 17 and under) records were closed.

An average of just under 2,000 clients were seen per month with approximately 25 percent being clients age 17 years and under.

Community support programming was emphasized in a continuing attempt to reduce the number and length of hospital admissions. Clubhouses have achieved and sustained attendance. The seventh BCMHC clubhouse opened in McCormick, making Restorative Independent Living Skills programs readily accessible in all seven counties. Our number of consumers involved in the supported employment program approximately doubled.

Last year 24 consumers were reported involved in either contract or temporary employment. At the end of FY 95-96, 52 consumers were gainfully employed, with 32 doing community contract work and 20 in center temporary employment.

The center's Volunteer Program was moved late this fiscal year to the supervision of our Supported Employment Project developer. This will allow more emphasis to be given the placement of consumers into voluntary experiences both internally and externally. During FY 95-96, volunteer investments of goods and services made to BCMHC totaled $183,775.00.

During FY 95-96, total quality management climate enhancement became a centerwide goal. Continuous evaluation based upon outcome and satisfaction measures were implemented.

Suggestion boxes were placed in all seven centers/clinics and administration in July 1995. Between July 1995 and March 1996, 38 comments and/or suggestions were published from staff and consumers.

Consumer satisfaction cards were made available in April at all suggestion box sites to facilitate feedback. By the end of June, 98 cards were submitted. A suggestion box committee regularly reviews the feedback, taking action as

deemed appropriate. Reports are given monthly to management team and regularly at quarterly All-Staff meetings to all employees. Instead of the latter, beginning July 1996, summaries will be included in BCMHC's monthly staff newsletter. Also beginning in July, additional boxes and cards will be provided to all clubhouses, day treatment, and free-standing Newberry Counseling Centers.

BCMHC has embraced the Total Quality Management philosophy that successful organizations are customer driven. As a service agency we have three tiers of customers. Our internal customers are our employees who must work as partners to serve the external customers. The community becomes our indirect external customer, and the client is our direct external customer.

With this in mind, BCMHC developed and conducted satisfaction surveys with each group. First to be completed was a 51 item employee survey in November 1995. With a 99 percent return rate, results are considered very valid.

The findings became the focus for a three-day management team retreat. Through an exhaustive process, 10 centerwide priorities for 1996 were established. These included: team building, crisis stabilization, staff development and training, internal communications, development of flex-time options, programs for the dually diagnosed, housing, expansion of school based programs, mobile service delivery capabilities, and programs for the elderly / mentally ill.

All employees were then asked to prioritize the top five needs from this list as they saw them for BCMHC. The first five listed above became the top choices.

Five quality teams were formed to address these issues. Any staff member having an interest in serving on a team could indicate a team of choice. All interested parties met during January All-Staff and elected membership .The teams have been functional since January 1996 and have accomplished much.

A monthly staff newsletter began in June for the purpose of improved linkage among staff. An improved interoffice mailing system now increases communication and better insures receipt of material distributed.. The selection of the annual Outstanding Employee was revised, allowing more complete participation. Management Team endorsed a structured flex-time option for employees subject to supervisory approval. Training opportunities are better publicized. Local training opportunities during All-Staff have been improved. A Total Quality Management initiative was developed and a grant submitted for funding to the S.C. Budget and Control Board to be implemented during FY 96-97.

In December 1995, approximately 100 community surveys were distributed. BCMHC received an approximate 50 percent return rate. Part of the purpose was to further educate other community resources about the Beckman Mission Statement. Each organization was asked how well BCMHC facilities were meeting this mission in each county. On a scale of one to 10, with 10 being "extremely well," 40 percent of our agencies scored eight or above.

Also in December, 266 consumer surveys were completed. Efforts were made to insure, as much as possible, feedback from all programs and demo-

graphics. Overall responses concerning clinic access were positive. Outcomes assessed showed 58 percent dealing much more effectively with daily problems; 64 percent feeling better about themselves; 66 percent in better control of their lives; 65 percent getting along better with family, 61 percent significantly less bothered by their symptoms, and 61 percent dealing better with people and situations which used to be problematic. The bulk of the remaining responses were not negative, but were rather in the undecided range. BCMHC Consumer Affairs Coordinator and Consumer Advisory Council continue to solicit and disseminate consumer feedback.

Following compilation of all data, dissemination conferences were held with staff in each office to review data for their county. Meetings were set up with other agencies where relationship challenges had been identified. The survey findings also became a focal point for the annual BCMHC Board of Directors Retreat in January 1996.

Management anticipates using this survey data as baseline and will continue in FY 96-97 to identify outcomes and levels of satisfaction from all customer tiers.

Leadership goals for FY 96-97 include full participation in a TQM initiative and team building experience. All permanent Beckman employees will receive an orientation to excellence in September 1996.

Following this, members of Management Team will participate in 32 hours of FrontLine Leadership Training over an eight week class schedule. Six identified employees will receive certification training as FrontLine Leadership Instructors and will then begin providing skills building opportunities for all BCMHC staff with supervisory responsibilities. Concurrently with TQM initiative, Beckman Center will provide ropes course experience for ten identified functional and geographic teams. This is intended to set the tone for submission of a TQM phase II initiative early in 1997 to move staff into Fourth Generation Management Principles.

Facility improvement continued to be a priority this fiscal year. A most notable achievement was the move in February 1996 by the Laurens Mental Health Center into a newly constructed, state- of-the-art building. The move rejoined adult and children's programs under one roof. It also located outpatient clinical services within proximity to clubhouse location, thus providing more efficient consumer access to services.

The facility also provides expanded group facilities and more convenient access to other agency service providers located within the medical industrial park. Laurens County has a history of resistance between the primary municipalities of Laurens and Clinton. The new location between towns attracts residents of both.

Two additional clinical relocations are planned early in FY 96-97. The needs in Edgefield and Saluda counties have far outgrown their present facilities. Negotiations are under way to provide expanded space.

"Pathways," Greenwood's adolescent day treatment program, relocated during the summer of 1995 to a homelike environment on the grounds of

Connie Maxwell Children's Home.

This allowed the program to function uninterrupted by activities of other programs sharing the previous location. Day treatment again negotiated a community partnership with Lander University to use campus facilities for a summer camp program.

This year for the first time activities were opened to other child and adolescent programs within our catchment area. Approximately 60 area youth are taking advantage of the experience provided by 12 BCMHC child and adolescent staff. Plans are to evaluate the program's success at the end of summer 1996 and begin to develop during FY 96-97 procedures for a summer 1997 youth experience.

As school based programs reach more youth during the school year, planning for continuity during the summer months becomes increasingly important.

Technological advances during FY 95-96 have enabled BCMHC to provide more efficient and effective service delivery. All seven county centers/clinics received upgraded computer functions within the Windows environment. All locations now have computerized scheduling capabilities.

BCMHC is the only location within DMH to use the third version of The Scheduler and the only one printing multi-client group tickets. All clubhouses have standalone personal computers, all but one with a printer. Consumers are learning computer skills as they perform clerical tasks. Finally, in FY 95-96, BCMHC Novell was upgraded to the 3.11 version.

Goals for the FY 96-97 year include continuing Novell upgrade to version 4.1 and preparing all support staff with increased word processing proficiency. Early FY 96-97 will see testing of two new Individualized Treatment Plan programs, one through CIS and the other free standing, with the goal of establishing computerized treatment planning with data retrieval capability.

As BCMHC continues to focus therapeutic direction on its mission statement, the task of gate keeping is ever present. Demand for services considered by the consumer as "emergency" remains high, especially in our three largest counties. Additional staff proposed for FY 96-97 include triage mental health professionals for Greenwood, Laurens, and Newberry centers. Also proposed are additional therapeutic assistant and/or clinical counselor positions to support the growing clubhouse populations in Greenwood and Saluda. An Activity Therapist position is planned for our largest clubhouse program in Laurens.

The business demands of a large and diverse center such as this have also created the need for two additional regional support staff, one in procurement and one in accounts payable. It is anticipated that all above positions will be filled during the first quarter of FY 96-97.

Programmatically, BCMHC expects to continue exploration of the development of crisis stabilization options for the region, especially located in Greenwood and Laurens counties. Development of housing opportunities also continues as a priority especially for the Greenwood County area. Beginning in the

spring of 1996, the Greenwood Mental Health Association began to explore the possibility of becoming the nonprofit partner with BCMHC and DMH for housing development. This effort was temporarily delayed due to the resignation of BMHC's Community Support Coordinator and liaison with this project. Activity levels will be reinstated with the designation of a new Community Support Program Coordinator expected during first quarter FY 96-97.

As The Beckman Center for Mental Health Services looks into the future of FY 96-97, possibly the largest single goal of its history faces its board and staff—readying the center for a Commission on Accreditation of Rehabilitation Facilities (CARF) Survey.

In July 1996, a CARF committee and coordinator will be named to steer readiness evaluation and preparation. Plans call for survey application to be made during the fourth quarter of FY 96-97.

Our center accepts this challenge as a vehicle to make Beckman Center for Mental Health Services even more viable in fulfilling its mission statement and providing for community needs. We look forward to the next twelve months of growth toward organizational maturity and continuous quality improvement.

Berkeley Community Mental Health Center
(Berkeley County)

The Berkeley Community Mental Health Center continues to make organizational and program changes which allow us to be more responsive to the needs/concerns of our clients.

We have employed three full-time child psychiatrists and have continued a contract with the Medical University of South Carolina to employ psychiatric residents. Having full-time physicians allows us to provide continuity of care and to screen emergencies at the center 51 hours each week.

We have expanded children's services by adding a family preservation program and a total of two school-based day treatment programs.

Staff were reassigned to provide intensive outpatient services specific to individual client needs. With additional resources, this service could easily allow us to provide more goal focused treatment and reduce hospitalization rates.

The center transportation service has expanded and is available to all clients who do not have access to other resources. We maintain consumer volunteers and employees in the clinical, administrative and maintenance divisions of the center.

We have computerized client scheduling and added a transcription service for physicians.

Through the efforts and support of the Low Country Mental Health Association, we have two apartments occupied by center clients.

The executive director and the assistant director of the Berkeley County Alcohol and Drug Commission meet at least monthly with the executive director, assistant director, and Emergency Services supervisor of the center to discuss program issues and alternative treatment for clients who are frequently

hospitalized. Both agencies work together to provide consultations on a 24 hour basis.

Due to budgetary constraints, several clinical and administrative positions were not filled during this year. This resulted in additional duties being assigned to staff. Many staff are to be commended for their positive attitudes and determination to provide the best quality care and treatment.

Major goals for FY 96-97 are to:

* make organizational and program changes which support utilization management, goal focused treatment, continuity of care and desirable outcome measures which include consumer satisfaction;
* continue to operate business in most cost effective manner; and
* attain CARF accreditation.

Catawba Community Mental Health Center
(York, Chester, and Lancaster counties)

The Catawba Community Mental Health Center provides services for an estimated 219,000 residents in Chester, Lancaster, and York counties. The comprehensive center has an administrative office in Rock Hill and clinical offices located in Chester, Lancaster, and Rock Hill.

The center currently employs 95 permanent staff and 6 temporary staff. There are 11 permanent staff positions vacant at this time. More than 2,350 open cases are serviced and maintained with a budget of $5,418,689.00.

Sources of budget are 41 percent state, 6 percent block grants, 3 percent county, 49 percent Medicaid revenues and other fees, and 1 percent other grants.

Centerwide psychiatric admissions have been reduced by 12.6 percent. Currently strategies that include filling some of the vacant 11 permanent staff positions are being developed that should reduce adult admission rates by at least another 10 percent. Alcohol and other drug admissions have been reduced by 20 percent and will be reduced by at least another 10 percent, when funds permit.

Intensive case management teams have been developed in Chester and York counties. As soon as the funds are available, an intensive case management team will be developed in Lancaster County as well.

Grants have been written seeking funds to develop additional consumer housing alternative in all three counties. A grant that was submitted in July 1995 for a 16-unit apartment community in Chester is moving forward.

Emergency services are now provided seven days a week, 24 hours a day, with face-to-face intervention in all three counties.

At the present time, five York County consumers are gainfully employed in full-time work. Also, one consumer is a student at Winthrop University with a major in computer science; and one consumer is a student at York Technical College with a major in Industrial Engineering. Both of these consumers are making good grades and doing fine.

The lack of an employment coordinator and transportation prevents Chester

and Lancaster counties from having a formal employment program for consumers. As a matter of fact, even in York County the lack of transportation has caused five consumers to lose their part-time employment. Strategies are being developed to address the problems of the lack of transportation and at least one employment specialist. The center works very closely with the Department of Vocational Rehabilitation to assist our consumers in finding employment.

DMH has stated that hiring of consumers as assistant case managers will be possible in the near future. This will would allow Catawba Center to hire and train those consumers in a number of needed areas such, as providing center transportation.

Strategies have been developed that would allow the establishment of larger community-based crisis alternatives. Funds needed to implement those strategies are not available at this time. Strategies have been developed which will improve our ability to do more community-based outreach, which includes hiring case managers, when allowed by DMH.

Written plans have been developed by physicians and clinicians that have increased the efficiency and effectiveness of our centerwide clinical programs.

Chester and York county Family Preservation Programs continue to be examples of excellence. Funds are still being sought to develop strategies that will allow the center to implement a Family Preservation Program in Lancaster.

Meetings have taken place with child and adolescent agencies for the purpose of developing strategies that would allow the provision of "extra curricular" programs. These programs would meet the needs of the three counties for community-based crisis stabilization alternatives for children and adolescents.

The need for services for foster families continues to increase at an alarming rate in our catchment area. In all three counties, at least one clinical person now works with foster families; others will be employed as soon as funds are made available.

Three full-time school-based clinicians are currently in Chester County, and one is in York County. Through the University of South Carolina Research Project, two student interns also work in Chester County and two in York County. Positions have been identified for Lancaster and York Counties and will be funded when funds are available. Currently there are no school-based services offered in Lancaster County.

In collaboration with schools, strategies have been developed and negotiations are still under way for the implementation of day treatment programs for children and adolescents. As an alternative to a planned school curriculum, York County offers the Cities in Schools program, which has been in place for a number of years. Chester County now has a similar program in place. There is no similar program in Lancaster County at this time.

A system for making referrals, staffing, and service delivery for special needs of children and adolescents has been developed and continues to meet most of the requirements for the Interagency System of Care for Emotionally Disturbed Children (ISCEDC). Wrap-around services through the use of local service providers and other community resources involving such components as Be-

havior Aids and "Shadows" have been developed.

The reorganization of administrative and support staff has been accomplished and continues to increase the efficiency and effectiveness in support of most of our clinical programs. The new DMH Client Information System continues to accelerate collection of Medicaid, automates back billing, and generally improves the center's collection efforts.

The Cultural Competence Committee, developed in 1995 with representatives from the three counties, continues to work very hard at completing an agenda that will hopefully aid all of us in our quest to make this Center culturally competent, as defined by DMH.

York County Adult Services has developed a number of new programs that have been instrumental in aiding York County's Department of Probation and Parole. Classes have been developed in the areas of conflict management and anger control for their probationers and parolees.

The public education program that the center implemented, which involves public speaking to school-aged children and adults, continues to be well received.

Goals for FY 96-97 are to:

* expand Intensive Case Management programs in each county office;
* increase physician coverage in all three counties;
* employ at least one child and adolescent psychiatrist;
* fill all existing clinical vacancies;
* increase nursing coverage at all offices by at least one full-time nurse;
* develop early childhood treatment;
* establish and improve relationships with all agencies that serve children and adolescents;
* evaluate child and adolescent summer camp programs of FY 95-96 for the purpose of developing and implementing positive changes;
* increase the daily attendance of all RPT programs by at least 25 percent;
* develop and implement strategies that will increase the number of working consumers in all three counties;
* reduce consumer admissions to inpatient psychiatric facilities by at least 15 percent;
* reduce consumer admissions to inpatient alcohol and drug abuse facilities by at least 10 percent;
* have an Intensive Case Management program in place in Lancaster County by January 1998; and
* have a Family Preservation Program in place in Lancaster County by January 1998.

Charleston/Dorchester Community Mental Health Center (Charleston and Dorchester counties)

The Charleston/Dorchester Community Mental Health Center continued to experience increased demand for its services. The active caseload increased by 18.8 percent to 3,610 by June 30, 1996.

Focus of services remained on adults with serious mental illness, seriously disturbed children, and persons with major crises needing short-term follow-up. Efforts to prevent psychiatric hospitalizations in DMH hospitals continued with the center having the lowest DMH hospitalization rate of all 17 centers.

The center ended the fiscal year with about a 1 percent surplus. Medicaid income again showed a significant increase ($1,348,000 over the previous year).

Administrative emphases included strengthening the computer department and medical records. One major leased office was closed as a cost-savings effort. After a six-year effort, a newly constructed Dorchester Clinic was opened along with an adjacent leased facility for a day treatment program. Efforts to purchase property for a new Charleston center continued.

The center received a major research grant involving young children and their substance-abusing parents. The project, a collaborative effort with the Division of Alcohol and Other Drug Abuse Services, is a sub-component of the Village Project, one of the 20 demonstration sites in the country offering comprehensive services to emotionally disturbed children.

Significant efforts were made in preparing the center for a managed care environment. These included staff training, use of a DMH-approved consultant, program reorganization, medical records efforts, computer enhancement, and movement toward accreditation.

The center invited reviews by several external observers including a DMH auditor and several patient advocacy organizations. The center led the state in developing written agreements with local residential care facilities where many center patients reside.

The center continued many collaborative efforts with the Medical University of South Carolina including inpatient services, several research projects, and joint employment of a number of psychiatrists.

Regarding the goals for FY 95-96, the center:

* completed the Dorchester Clinic building project;

* shifted sites for a new Charleston Center building from North Charleston to West Ashley; and

* implemented several projects related to managed care including implementing new productivity standards, established a pilot project for non-funded clients, and started formal collaboration with DAODAS and MUSC around future joint projects.

Goals for FY 96-97 are to:

* purchase property for a new Charleston Center;

* complete formal application and preparation for CARF accreditation; and

* establish a new adult "access" unit to manage the efficient entry of patients into the center system.

Coastal Empire Community Mental Health Center
(Allendale, Beaufort, Colleton, Hampton, and Jasper counties)

For FY 95-96, Coastal Empire Community Mental Health Center recognized

the need to be fiscally responsible and, at the same time, not compromise its clinical goals.

During this past fiscal year, the center accomplished many important goals while eliminating a projected budget deficit. At the beginning of FY 96, the DMH Financial Services Division estimated that the center would end the year with a deficit in excess of $600,000. Through immediate and concerted efforts in managing the budget, the center reversed this trend within three months and ended the fiscal year with a small fund balance.

The center made significant progress toward its goals for FY 95-96 by:

* completing three remaining construction projects in Beaufort and Jasper counties and on Hilton Head Island—presently, consumers are being seen in these modern facilities and, with these buildings operational, all six clinics are now in new facilities;

* serving 3,403 consumers with a total of 67,396 contacts;

* expanding group services with a 48.42 percent increase in group contacts from the previous fiscal year;

* decreasing the use of DMH adult inpatient psychiatric facilities by 25 percent, a significant change—our goal had been to not exceed 100 per 100,000 population, and we were within 2.6 of that target;

* successfully implementing a model school violence intervention program in the Estill school district in Hampton county and Jasper county school district—both programs have received very positive comments from both school districts' officials;

* implementing computerized scheduling—work continues on other routine tasks that can be computerized, including employee related information, vouchers, etc.;

* receiving on-site consultation from Psychiatric Integrated Services, Ltd. Consultants to prepare for managed behavioral health care;

* obtaining training from the Department of the Navy on Parris Island in the principles of Total Quality Management—16 staff members attended for a total of 522 hours; and

* improving housing for psychiatrically disabled adults when Canal Apartments opened in January 1996—this 12-unit apartment project was fully occupied within the first month and providing housing for 12 consumers; the apartments are owned by Beaufort-Jasper Mental Health Association and were funded in part by DMH.

Key goals for FY 96-97 are to:

* increase services to severely emotionally disturbed children and adolescents by providing a full time in-school position in the Allendale county school system;

* develop a comprehensive training plan for clinical staff that will address common and individual needs;

* ensure compliance with SCDMH Division of Financial Services Financial Policies and Procedures by conducting two internal audits and implementing timely and appropriate corrective action;

* apply for accreditation through CARF or JCAHO;

* continue to develop policies and procedures which are cost effective and position the center for managed behavioral health care; and

* continue to cooperate with non-profit organizations to make housing available to the center's seriously mentally ill consumers—efforts will be concentrated on helping secure funding for apartments in Jasper county and on increasing the number of Canal Apartment units from 12 to 20.

Columbia Area Mental Health Center
(Richland and Fairfield counties)

FY 95-96 was a year in which the center's board of directors and staff were consumed by budgetary concerns and uncertainties about changes to our health care system. In spite of enormous challenges, the center made solid progress in implementing needed changes.

At the beginning of the fiscal year, the center had extremely ambitious plans for new program expansion: a day activity therapy program for the Lower Richland area; an expansion of the daily activity program in Winnsboro; additional intensive case managers; children's intensive case managers; counselors to treat Proviso assigned children; and an expansion of our Dialectical Behavior Therapy Program.

In all, over $1 million in new revenue was to be generated through program initiatives and expansions, adding many new clinical positions to the center and greatly expanding service delivery.

These were our plans in July and early August. By the end of August, however, the Department, listening to all of the best advice from political pundits and experts, began to advise mental health centers across the state to prepare for immediate and severe changes in the national health care system. We all believed that, before the end of September, Congress would sign and the President would approve a complete redesign of the Medicaid system. Gone would be the days of fee for service and expansion. We were told to get ready to cut our expected revenues to those of a few years ago, with a hard freeze on the number of dollars we could gain no matter how much service we provided. Program initiatives were quickly placed on the shelf, and we began to question what, out of the existing mix of services, we might also have to cut.

This was especially bad news, since the center was depending on these new services not only to pay for themselves, but to help pay for other initiatives that had been implemented previously. By early September, the center was projecting deficits of between $700,000 and $1 million, depending on which scenario of federal legislation was implemented.

We instituted immediate, drastic, some would say Draconian, measures to control spending. Needed positions went unfilled. Program expansions that would have served clients were placed on the shelf. Technology purchases that might have made some staff more efficient were not made. Some conferences and training that might have improved staff skills were not attended. Only those expenditures that seemed most necessary were made. Through a combi-

nation of luck, the changing political winds, hard work, and prudent budget management, the center ended the year in the black. The feared changes toward block grant funding did not come about. The center changed directions several times, depending on quick but careful readings of the political winds.

Instead of the large deficit we could easily have had, we ended the year with a small carry over. However, this "surplus" came at the expense of needed client care. Some staff and some client advocates questioned our decisions, even saying that we should move ahead with some initiatives regardless of the budget.

No one liked the steps we took, but they were essential to the financial health of the Department of Mental Health. We took them and we managed to meet our financial goals for the year.

In spite of the adversity we faced, there were a number of significant clinical achievements during the year. Part of our projected deficit was due to the first full year of operation of our Marshall Street Crisis Stabilization Facility.

This program, combined with the new crisis beds the Department gave to Richland Memorial Hospital, and other program initiatives within the center contributed to a 21 percent decline in admissions to DMH psychiatric inpatient facilities during the year. This is a significant achievement, helping the Department move toward its goal of downsizing hospitals in order to move funding toward the community.

In addition to the uncertain funding we faced for the Winnsboro and Lower Richland day programs, other concerns hampered our progress.

We were unable to locate a suitable building or a suitable builder for an expanded day program in Fairfield County. After years of tolerating a substandard building for the program, the center moved out. Instead of closing the program, staff found a way to continue to deliver the service to clients in a safe, clean environment.

Lower Richland staff, unable to fully staff a large activity program, changed gears, implemented a limited program, and served previously isolated, seriously mentally ill community care home residents. Both of these initiatives were difficult for staff, but essential to improve the quality of life for clients. Staff took on these challenges and succeeded, in spite of forces that could have resulted in poorer client care.

As 1995 closed, the center undertook far-reaching changes in the organization of adult, clinic based services. These changes were designed to make core psychiatric and case management services more accessible and available to the seriously mentally ill adults of Richland County.

Clinic-based nurses were going to move out of case management roles and into the roles they were trained to perform— being nurses.

Emergency services workers would stop performing intake and do the jobs they had been hired to do—be the center's emergency room.

Clinics would be reorganized to admit new clients who were not emergencies, assign them to the most appropriate level of care, treat individuals with the most efficient service modalities. In order to perform these tasks, new staff

would be hired.

Parts of this dream came true. Nurses were organized into the community mental health's first "nursing service," which has been generally viewed as a rousing success.

However, other parts of the plan were not realized. Case loads grew from around 100 clients per case manager to over 130. There were significant stresses for clinical staff as they tried to fit into a new, but only partially changed, service system. Clients were confused as physician and case manager assignments changed.

Through the hard work of staff and the tolerance of clients, we worked through the always difficult process of change—especially incomplete change—and got back on an even footing. Service delivery held up and even increased slightly. There were fewer adverse incidents than the previous year. After initial confusion, staff service tune levels went back up to previous levels and, in some cases, even higher levels.

The center's intensive case management programs also had a difficult time this year. Staff resignations decimated these programs, as the center lost nearly half of its combined Network, Elder Support, and Geropsychiatric Program staff.

Faced with the challenges of serving severely mentally ill individuals through assertive outreach, the center made major changes in the organization of these programs. After timely but careful planning, the center consolidated clients and staff from all three programs into one program. Through consultation with the clients, individuals who no longer needed the intensity of care previously provided were transferred to less intense services. The 24-hour-a-day coverage few clients needed was dropped from the program while still ensuring that individuals had complete access to acute care, as required, through the center's 24-hour emergency services program.

In spite of these setbacks and concerns, the center made real strides in improving quality of care during the year. Adversity forced senior managers to face up to some difficult realities. Changes were made in spite of difficulties. Relations with advocacy groups improved through careful cultivation of understandings and demonstration by staff of an openness to working with these individuals. Staff became more aware of the interests and concerns of consumers, and "customer relations" improved as a result of several workshops and numerous administrative discussions.

Few program initiatives are planned for FY 96-97, but the center does have some ambitious goals:

* Careful addition of staff to key clinics will occur.

* The center is planning to apply for CARF accreditation for some of its programs during the year.

* There will be increased and improved monitoring of programs for clinical efficacy.

* There will be an even greater emphasis on customer relations, client satisfaction, and ensuring that clinical service delivery represents high standards of

care.

* We will carefully evaluate the operation of Marshall Street Crisis Stabilization Facility to determine whether the program can be operated for less cost.

* The center will also continue its system-wide efforts to further reduce the hospitalization rate of catchment area residents.

* We will also attempt to locate adequate building space for staff, clients, and programs as the lease expires for one of our central operational and clinical locations.

We have been through a very tough year, but we are ready to use the experience to overcome all of the barriers we can to improve care to clients who depend upon us for services.

Greenville Mental Health Center
(North Greenville County)

In FY 95-96, the Greenville Mental Health Center continued its commitment to providing services to the seriously mentally ill and children.

The number of open cases continued to hover around 3,000 with 2,991 cases open at the end of the fiscal year. Individual contacts, a reflection of the total work accomplished, continued to exceed 10,000 per month with 120,110 contacts this fiscal year.

During this year the number of employees fluctuated from 94 in the beginning of the fiscal year to 85 at the end of the year. Most of these vacancies will be filled by October 1996.

The center's Consumer Affairs Coordinator continues her active role by implementing family, consumer, and community satisfaction surveys (in conjunction with our Quality Assurance Coordinator), organizing a monthly SHARE group, and increasing consumer input into center services and programs. We have also implemented a quarterly centerwide newsletter (recommended by the board of directors following feedback from the Community Survey).

The center is developing program descriptions, admission criteria, etc. for each center program. This information will be included in handbooks for community agencies and consumer orientation manuals in order to enhance access to services available at the center.

We have continued to refine our walk-in system of appointments and the fusion of Adult and Emergency Services into Acute Care Services. We are studying ways to improve the efficiency of our intake and scheduling systems and have recently revised our follow-up procedures to encourage staff to consistently follow-up with no-shows to improve continuity of care.

The mental health center started the year with a carry-over deficit of $142,000. We have developed strategies that we feel will significantly decrease this deficit by the end of the fiscal year.

Medicaid revenues increased by 4.4 percent for the year. Due to a change in Medicare reimbursement, revenue from Medicare decreased by 34.5 percent.

An increase in self-pay revenue (18.8 percent) and insurance revenue (58.8 percent) allowed the center to increase its overall revenue by 2.8 percent — $2,339,506 in FY 95-96 compared to $2,276,825 in FY 94-95.

The center continued its emphasis on training and education with medical students, residents, psychology interns, social work interns, and nursing students rotating through the center during the year.

We are extremely proud of Tom Vinegar who received statewide recognition as the Outstanding Child/Adolescent Family Services Employee. This is the second year in a row that a center employee has been selected for this honor. Kevin Mallory, from the Child, Adolescent and Families (CAF) unit, was also appointed to the Governor's Excel Leadership Program.

We have made considerable progress in meeting our goals for FY 95-96.

The center reorganized and expanded nursing services by implementing a Nursing Referral Form to enhance access to nursing services and by providing part-time nursing services to the Child and Adolescent Unit and Senior Adult Services. We are working toward providing nursing services in all program areas.

We are in the process of reorganizing our case management services to ensure access to all center programs for clients in need. We have developed an Internal Referral Form to facilitate referrals between programs and to improve communication and feedback between clinical staff.

The center has explored options for after-hours services and has developed an agreement for 24-hour observation beds for consumers seen at the emergency room with a psychiatric crisis during periods of time when the center is closed. We also continue our close working relationships with the Help Line and staff at local emergency rooms.

The center has completed a vocational survey of consumers to assess needs, current work status, and impediments to work. We have also begun a joint project with the Mental Health Association (Mental Health Partnership Grant) to evaluate vocational needs of consumers in Greenville County.

Child, adolescent, and family staff continue their close working relationships with community agencies and consumers through their involvement with interagency staffing conferences and community-based services — BabyNet, DSS, School-based Services, Family Preservation, Children's Day Treatment, etc.

The Department has developed and the center has implemented new cost centers and productivity report systems during the last quarter of the fiscal year. With these new systems in place, we will be able to track and monitor both costs of services and productivity levels of clinical staff at the center. The center has begun several projects to develop outcome measures for clinical services in our CAF and CRS programs. We will be focusing more on this aspect of care as we develop outcome measures for accreditation in this fiscal year.

Goals for FY 96-97 are as follows:

* continue to evaluate our treatment programs with effort to ensure need/

service match in our service delivery by the following: (a) redevelop CSP services from the standpoint of cross training, team approach, and outcome measures; (b) evaluate C&A programs by use of outcome measures; (c) attempt to increase prevention efforts, particularly in C&A, looking at linkages to behaviorally disturbed children and long-term outcomes; (d) explore alternative programs and services to the elderly;

* formalize linkages with primary health care providers through contracts/ MOA's/policy development;

* develop dual-diagnosis manual and redevelop MOA with DAODAS;

* develop Acute Care Services to reflect consumer-friendly access, some aspects of utilization management, and group and short-term treatment modalities;

* further develop case management to include all aspects of our center and utilize some consumer involvement in the process;

* ensure access to transportation by Medicaid and non-Medicaid populations; and

* pursue accreditation by nationally recognized accreditation body.

Lexington County Community Mental Health Center (Lexington County)

The Lexington County Community Mental Health Center continued to expand service delivery during FY 95-96 with the development and implementation of new programs and new partnerships with community and government human service agencies.

The following goals were met during the year:

* Land was purchased for the proposed Child, Adolescent, and Family Facility and the Acute Care/ Administrative Services Building.

* Partnerships with community agencies were expanded with the implementation of the Lexington Alzheimer's Partnership. The program was designed and co-funded by the Department of Mental Health, Lexington County Agency on Aging, the Governor's Office on Aging, and the Robert Wood Johnson Foundation. Indigenous community members provided outreach programs and respite care for caregivers of Alzheimer's victims.

* The TLC Supported Apartment Program and the Homeshare Program reached their goal of serving 65 clients.

* The Friendship Center Gault Grove Apartment Complex opened and provides housing for 20 clients in an outstanding HUD project. A second HUD housing development is being planned in conjunction with Friendship Center, thus expanding housing opportunities for Lexington County citizens with mental illness.

* The Program for Dually Diagnosed clients, a joint project with the Lexington/Richland Alcohol and Drug Abuse Center (LARADAC) and Hall Institute, is fully operational.

* The Child, Adolescent, and Family Program continued to increase services with the implementation of the Family Preservation Program and the develop-

ment of School Based Services in four of the five school districts in the county.

* Psychiatric services were expanded throughout the center with the addition of evening and weekend clinics.

* Relationships with colleges and universities were enhanced with additional training opportunities for psychiatric residents, psychology, and social work students, and nursing candidates.

* Proposals for a Family Crisis Intervention Program were submitted to various funding groups.

* Revenues were maximized with the streamlining of the Accounts Receivable section, better computer capability, cost-center budgets for programs, and the implementation of a central financial triage system for adults.

Goals for FY 96-97 are to:

* implement the financial triage system centerwide;

* continue to develop community based treatment options to reduce admissions to state inpatient facilities;

* develop partnerships with local medical facilities, physician organizations, and home health agencies to maximize quality care for our clients;

*pursue national accreditation for the center;

* complete the construction of the Child, Adolescent, and Family and Acute Care/Administrative Services buildings;

* increase clinical services in the Lexington County Detention Center to seven days per week;

*implement a school based day treatment program in conjunction with one of the school districts in the county;

* expand school based services in the county school system; and

* develop contracts with nursing homes to provide mental health services to residents.

Orangeburg Area Mental Health Center
(Orangeburg, Bamberg, and Calhoun counties)

The Orangeburg Area Mental Health Center continued to focus on increased awareness of consumers' needs, additional development of community resources, and renewed efforts in having a new facility constructed to meet the needs of a growing clientele.

The reduction of psychiatric admissions and readmissions to state facilities remains a priority for center staff.

To accomplish this goal, a restructuring of the organization emphasized increased intensive case management, a separate intake assessment unit, additional staff for crisis stabilization, increased frequency of high-risk management team meetings, and increased numbers of caregiver groups for families of consumers.

Diversionary services for children and adolescents as an alternative to inpatient and residential placements was obtained through increased presence of C&A staff in various school systems within the catchment area. Restructuring of the unit combined C&A and adults to provide a more integral level of care

component. A C&A Summer Camp was implemented with over 60 youths in attendance.

The school-based counselor program was expanded by providing services at another site with an additional staff. Intensive case management, more parenting classes, and caregiver groups for children were implemented in the Family Services Unit.

The Child Proviso Initiative was fully implemented in the entire catchment area.

Employment opportunities increased by 25 percent with consumers participating in more voluntary efforts in the community.

Volunteer utilization became prevalent in each program in the center, with an increase of 13 percent.

The administration of a Customer Satisfaction Survey indicated an overall excellent rating of services from consumers.

Architect plans and the site for the new clinic to be constructed in Calhoun County were approved.

In FY 95-96 there were 2,564 admissions and 60,791 direct contacts.

Goals for FY 96-97 are to:

* develop short-term and long-term strategies toward managed care;
* reduce the caseload in the clinics by at least 30 percent;
* become fully accredited by CARF;
* computerize all clinical programs at least 30 percent;
* increase school-based services throughout the catchment area; and
* implement a special program to increase and assess the needs of Department of Social Services referred consumers.

Pee Dee Mental Health Center
(Florence, Darlington, and Marion counties)

Pee Dee Mental Health Center has continued to provide efficient and effective services to consumers in our catchment area.

We completed a pilot program which makes it quicker and easier to access services at our center. Even though we have reduced the amount of psychiatric admissions to DMH inpatient facilities to less than 40 per month, we are continuing to explore development of crisis/respite beds as an alternative to inpatient hospitalization. We are exploring this issue with community-based providers in our area.

Linda M. Summer Family Services has been reorganized. There are now 13 clinicians in family outpatient services. We have developed positions for one full-time employee who is working with abused children and is out-stationed at the Durant Children's Center in Florence, as well as one full-time employee who is providing school-based services in Darlington County. Also, we have two Family Preservation programs. Plans are under way for an additional school-based program.

New Independence Clubhouse moved into its new location in the fall of 1995, and an Open House was held in April 1996.

Additional housing was made available to our consumers with the renovation of a house donated to the center and by the opening of New Hope, a 12-unit apartment complex. These projects provide housing for fourteen consumers and the two children of one of them. Two of the apartments at New Hope have been specially adapted for consumers with hearing disabilities.

The center's Consumer Employment Program continued to expand, with 23 consumers presently working in the private sector. Overall employment, including transitional employment programs (TEP's), has been found for 35 consumers.

We are moving forward with our plans for a new building in Florence County. Obtaining an appropriate site which is readily accessible to consumers continues to be a challenge. The center board Site Committee is considering several possible locations.

Because we continue to experience funding cuts, we had to close Halcyon House, our six-bed short term residential program for children ages 12-17. Closing this program necessitated the reassignment of eight staff members to positions in other clinics.

As we look toward the changes that may occur with managed health care, our physicians have begun implementing several new programs that will help us prepare for these changes. These include: physician chart reviews, medication follow-up criteria, AIMS, and group therapy training for Center clinicians.

We were proud that two of our staff members received recognition at the state level this year. Craig Goss, our community resource developer, was recognized by the South Carolina Mental Health Association for his work by receiving the Carol Garvin Volunteer Program Award.

Leesa Campbell, program coordinator at New Independence Clubhouse in Darlington County, was appointed to the Governor's Excel Leadership Institute, a year-long program enhancing the professional development of outstanding employees.

The movement toward managed care has made it imperative for us to look at the services we are providing and to implement continuous improvement in the quality of already existing programs.

In response to the center's needs, members of our Executive Management team have drafted a new vision statement which seems to embody the direction our center is taking.

Our goals for the coming year evolved from ideas generated by our Executive Management Team at our annual Leadership Conference earlier this year.

The goals for FY 96-96 are to:

* strive to be recognized as the premiere provider of Behavioral Health Care in the Pee Dee by consumers, community leaders, agencies, other health care providers, and the community at large—a Marketing and Community Service/ Education campaign will be developed and implemented;

* provide accessible, comprehensive, and effective services for all behavioral health care needs. This will be accomplished through: consumer surveys and needs assessments, CARF certification, development of more clinical treatment

groups, and implementation of the Level of Care model in all clinics; and

* create a comprehensive MIS system in order to adapt to the changes in the health care environment—we will pilot a computerized scheduling system, design and implement Consumer Satisfaction Survey software, and develop outcome measurement tools to aid in decision-making about programming.

Piedmont Center for Mental Health Services
(South Greenville County)

The Piedmont Center for Mental Health Services serves southern and eastern Greenville County, a rapidly growing area in South Carolina with a wide diversity of industries and businesses. The area is experiencing a tremendous influx of new businesses and high technology industries. This is accompanied by many new housing starts, new apartment complexes, and new families moving into the area.

To serve the growing population, the center has full time offices in Simpsonville and Greer and a part time office in Piedmont. Simpsonville is now the fastest growing town in South Carolina. The catchment area population has grown to approximately 165,000 and is projected to continue rapid growth into the next century.

Serving the seriously mentally ill continues to be a top priority of the center. There are numerous community based programs to provide services to this population.

The center, through contractual arrangements, places clients in eight 10-bed community care homes, Ridgeview Community Care Homes, and Gregory's Community Care Homes II. The center provides a Rehabilitative Psychosocial Therapy Program and other supportive services for these 80 clients.

The J. Charlie McKinney House, a 10-bed community residential program for the deaf mentally ill, was completed and opened with 10 residents in July 1994. A full range of rehabilitative services are provided for these clients with trained staff twenty four hours per day.

In addition, the Piedmont Center employs professional staff to provide outpatient and case management services to the deaf mentally ill in the region.

The center contracts with Gateway House to provide a program of psychosocial clubhouse services for 30 clients. The clients live at Gateway Apartments, Portals Apartments, Towers East Apartments, or Carolina Retirement Center. The Hillcrest Heights Apartments provide residencies for 12 patients. These 12 apartments were constructed with a HUD grant to the Greenville Mental Health Association.

Twelve new apartments, Victor Village, were completed and opened in early 1996 for clients in the Greer area. This is another partnership project with the Greenville Mental Health Association. Gateway House provides supportive employment services for selected clients. The center also uses the services of Goodwill Industries and Vocational Rehabilitation.

The center operates Sunshine House in Simpsonville, which is a Restorative Independent Living Skills Program, and Rainbow House in Greer, which has a

similar program. "Crossroads," a rehabilitative psychosocial clubhouse, opened in Piedmont in February 1995 and serves 15 clients. The center contracts with Marshall I. Pickens Hospital, Chestnut Hills Psychiatric Hospital, and Charter Hospital of Greenville to provide local inpatient stabilization for mentally ill clients needing acute care. Other local hospitals are utilized when clients have resources to cover the cost of inpatient care.

The center relates closely with Harris Psychiatric Hospital, which serves Region B of the state. For children, the center contracts with Marshall I. Pickens Hospital Child and Adolescent Program, Anderson Youth Treatment Center, and Charter Hospital for local emergency stabilization.

The center provides a family preservation service for high risk children. All children in this project are in threat of being removed from the home and placed in a Department of Juvenile Justice (DJJ)) or DMH institution. This program functions in close collaboration with the DJJ and the Family Court.

The center provides community residential treatment services for children ages 11 through 16 in the Clear Spring Home for girls and the Bethany Home for boys. The Piedmont Center has collaborated for several years with Bryson Middle School where a full time mental health counselor and a part time clinician have been placed.

The center employed and placed mental health counselors in Fountain Inn Elementary School and Woodmont High School in August 1994. These counselors work with children and parents and provide consultative services to teachers and staff. Research is included in these projects.

Graduate students from the University of South Carolina serve internships in all school based programs. Other graduate students serve internships in the Simpsonville and Greer offices and clubhouse programs. Since July 1994, the center has collaborated with other agencies to carry out the "Children's Proviso."

The center has two full-time mental health counselors who work with high risk and troubled children referred by the Department of Social Services.

The Piedmont Center made much progress toward the goals established for FY 95-96. The goals and responses were to:

* fill the vacancy for a Consumer Affairs Coordinator— plans are completed to fill this position by December 31, 1996;

* further prepare and position the center for functioning in a managed care environment — the center is working collaboratively with Region B Centers and Harris Hospital and a consultant to prepare in key areas for managed care;

* fully evaluate the "Access" services of the center and make necessary changes to improve access to needed care, enhance quality of care, and to become more cost effective— the center constantly monitors this process with use of computer programs and reports; productivity standards have been set and are monitored. Utilization management processes are being tested; quality in patient care is emphasized and monitored carefully;

* add a second counselor to network with the Department of Social Services to serve at risk children— this position was filled during the fiscal year and is

functioning well;

* begin construction on the planned new facility for the Center in Simpsonville— everything is in a state of readiness except finances for the project, construction bids will be sought when funds are available; and

* hire a technically trained person to provide necessary support for the computer network. (This position may be shared with other Region B centers). This position was added and filled in mid-year. This service has proved to be very valuable for the center and region.

Another accomplishment was that the center hired a full-time medical chief in February 1996. Another full-time psychiatrist began July 1, 1996.

The center had very impressive statistics for FY 95-96 which include: total number of patient contacts—73,696; Medicaid receipts—$2,876,110.00; and admissions—1,287

Serving the seriously mentally ill and emotionally disturbed children will continue to be top priorities.

Goals for FY 96-97 are to:

* fill the vacancy for Consumer Affairs Coordinator by December 31, 1996;

* continue to adapt and position center for continuing changes in the health care delivery environment.

* continue the managed care efforts with the other centers of Region B and Harris Hospital;

* provide needed training in "Brief Therapy" and other essential topic areas for outpatient clinicians;

* begin construction on the planned new facility for the Center in Simpsonville;

* review, evaluate, and make needed changes in treatment and services for chronic mentally ill patients; and

* apply for CARF accreditation by May 1,1997.

Santee-Wateree Community Mental Health Center
(Sumter, Clarendon, Kershaw, and Lee counties)

As in previous years, FY 95-96 continued to be one of challenge and transition at Santee-Wateree Community Mental Health Center.

One of the most significant events involved the shift from utilizing Hall Psychiatric Institute as the center's designated inpatient unit to utilizing Bryan Psychiatric Hospital. This transition occurred with minimal apparent disruption to our consumers, but was nevertheless painful, in that it altered a 25-year relationship that had existed between this center and Hall Institute.

The center made significant progress toward established FY 95-96 goals. Following are the outcomes achieved for each previously established goal:

Goal 1: Relocate Sumter Children, Adolescent and Families (CAF) Services to allow better service to consumers and their families. The center, working in conjunction with the Logan Foundation, was able to lease on a long term basis, a location that was specifically designed to meet the needs of our younger population. This facility contains almost 10,000 square feet of space that is

child/youth oriented and is located near primary care medical facilities. This move has allowed all of our current CAF programs to be housed under one roof. The building is also designed to allow better medical and nursing services for this population.

Goal 2: Relocate the Bishopville Clinic. This goal was also accomplished, although with much less success than that of the first goal. We were able leave our old Bishopville location, which was a turn of the century house, and relocate to a single story handicapped accessible traditional office location. Although we solved one set of problems with this move, we created more in that we lost over half of our old square footage with the move. We will continue to look for more suitable office space in Lee County.

Goal 3: Begin a crisis stabilization unit. In anticipation of the closure of our inpatient unit at Hall Institute, the center began an earnest assessment of the most cost effective way of reducing admissions. Already in place was a local inpatient unit that accepted over 50 percent of our admissions. Still, the addition of this catchment area's admissions to Bryan Hospital would risk a census over capacity on many days at the hospital.

The decision was made to begin an intensive day crisis stabilization program. It should be noted that this effort was one that was handled totally on a local level by shifting staff resources and did not require any additional money from Columbia.

The Crisis Stabilization Unit began operation last September and has statistically impacted on our admissions to Columbia inpatient facilities. This impact has been reflected in Community Mental Health Services Key Performance Indicators that are published monthly. This program has worked closely with the local hospital, drug vendors, and local labs.

Goal 4: Expand Staff Training and Development Program. As the center shifts toward managed care, the decision was made to expend more resources in this area. A full-time staff position was dedicated to this task. This unit is now responsible for all new employee orientation, monthly OSHA and safety training, monthly in-service training, as well as special training for programs and tracking licensure requirements for multi-disciplines of staff.

Goal 5: Relocate administrative offices. This goal was not a priority so much for administrative purposes, but rather was part of the overall plan to increase office space at the main center office for clinical functions. An assessment of the current clinical services at the Sumter office, the connectivity between programs, and the sharing of administrative resources such as clerical staff, medical records staff, billing, etc. proved that splitting a clinical program from the main building would not be a cost effective option. Also, with the addition of the Crisis Stabilization Unit, it was recognized that there needed to be some continuity of staff between acute care services, short term services and case management; and that this would most likely occur with these services housed in one building. By the process of elimination, the decision was made to move the executive and business offices out of the main center. This move was accomplished last November.

Center goals for FY 96-97 include are to:

* seek national accreditation—the center will apply to CARF for a survey in the spring of 1997;

* increase psychiatric coverage—the center will begin an active recruitment process to obtain a full time child psychiatrist; the center will also seek to increase psychiatric time available for our adult consumers;

* fully implement the Federal Supportive Employment Grant—this will include the training and implementation of IPS and PACT-IVR Teams;

* begin a centerwide Utilization and Review Process; and

* encourage all staff who are qualified to obtain licensure and credentialing in their field of study—provide supervision activities at the local level where possible for staff pursuing licensure.

Spartanburg Area Mental Health Center
(Spartanburg, Union, and Cherokee counties)

Following is a summary of our center's progress toward the goals we identified for FY 95-96:

* Remain financially sound: It was our continued intent to remain financially sound. We again worked our way out of a deficit and ended the year with a carry-over. Both clinical and administrative staff were commended by the Board of Trustees for this accomplishment.

* Retain current staffing level and fill other vacancies as funding is available: There was an overall loss of one clinical staff and an overall gain of seven administrative support staff. (Twelve clinical staff were hired while 13 resigned/retired. Nine administrative support staff were hired while two resigned.) Eight of the 10 clinical staff hired were in Children's Services and three were in Community Support, clearly reflecting DMH/SAMHC priority populations. Two of these new clinical staff were assigned to the Union satellite and two to the Cherokee satellite.

* Purchase a site for a new main center and hold ground breaking: No property has yet been purchased even though appraisals were done in April 1994, April 1995, and most recently in June 1996. (SCDMH approved funding in November 1992 and an architect was chosen in November 1993.) The Board of Trustees is eager for a new building in Spartanburg to be built; however, locating a suitable site at an acceptable price has been difficult.

* Resume Family Preservation: Over the last eight months, all three clinical staff have been hired for this program. Actual services began March 5, 1996, and by June 30, 1996, 11 families have been served with a total of 29 children receiving services. We are now providing access to Family Preservation services to DSS/ISCEDC children in addition to those referred from other sources.

* Collaborate with Region B and SCDMH in preparation for managed care: Hundreds of hours have been spent, mostly by a core group who were active in Region B's five committees, but including virtually all staff to become "fluent" in the language of managed care as well as to participate in the design of tools and procedures to adjust to the changing health care market. Some of our staff

have had leadership roles in statewide presentations. Our director continues efforts with other Region B directors toward implementation of some ideas.

* Provide extensive Novell training for two administrative CIS employees: This training was provided. The systems administrator and back-up to this position attended the Novell administrative classes in Columbia.

Other Accomplishments for the year:

* Total client contacts for FY 96 were 92,272 (FY 92: 62,340; FY 93: 66,070; FY 94: 77,600; FY 95: 89,566) of which 11,905 (FY 92: 7,898; FY 93: 10,280; FY 94: 12,163; FY 95: 11,896) were through New Day Clubhouse.

The unduplicated number of clients served was approximately 6,249 (FY 92: 5,080; FY 93: 5,150; FY 94: 5,721; FY 95: 5,934) of which 155 (FY 92: 133; FY 93: 154; FY 94: 150; FY 95 136) were served at New Day.

* Overcoming numerous funding and regulatory issues, the social detoxification center for the Spartanburg area is to open in 1996.

* Volunteers contributed the equivalent of $84,505.35 through 9,389 hours of service. These 23 people were formally recognized at an event to which staff and Board were invited.

* A successful Quality Assurance Survey was held in mid-September 1995.

* Through Consultation and Education services, 29 staff members provided 580 offerings for a total of 1,943 hours. Twelve thousand nine hundred twenty-nine dollars and nine-six cents ($12,929.96) were collected for these indirect services.

* Without a program director, the Community Support Program worked with the assistant director to reorganize into case management, medical, and liaison services. Some staff were also deployed into this department.

* Non-hospital Intensive Care resources were deployed into a Stabilization Team to offer a broader range of services to clients in crisis.

* Board Vice Chairman Hal Warlick testified at a hearing held by members of the South Carolina General Assembly in support of Medicaid services to our clients.

* An orientation and tour was offered to the new Director of Spartanburg Public Safety.

* The March meeting of the South Carolina Mental Health Commission was hosted in Spartanburg after an informal visit by Commission Chairperson Mrs. Elizabeth Forrester in the fall of 1995.

* Memoranda of Agreement were signed with Community Care Home operators serving our clients in the three counties. Data for tracking both the clients in those homes and the homes themselves is now on a personal computer.

* Permission was sought and granted to remove the case load cap for the Union intensive case manager to allow greater flexibility in providing services.

* Spartanburg Area Mental Health Center responded to the opportunity to participate in the Clinical Rehabilitation Team (CRT) efforts so as to receive training and consultation. We eagerly await implementation of this model.

* "Video-phone" capacity came on-line so that deaf clients in Spartanburg could have psychiatric medical assessments by a psychiatrist in Charleston

who can communicate with the deaf.

* Use of the centralized "Scheduler" capacity began in Spartanburg.

* A decision was made late in the fiscal year to pursue CARF accreditation as recommended by SCDMH.

* Continuing efforts of note include: Continued monitoring of Continuity of Care requirements; continuing outposting of a staff member at the Village Partnership; an annual staff development retreat; staff development offerings based on an annual needs assessment and sometimes providing CEUs; providing clinical experiences for a variety of students. producing an internal newsletter; sharing a position with Vocational Rehabilitation; an increased emphasis on safety for clients, visitors and staff; continued consultation to Woodruff Health Care; continued leadership in the Homeless Coalition; support of the Mental Health Partnership and its current focus on work options for clients; and continued participation with various local authorities in Emergency Preparedness.

Goals for FY 96-97 are to

* remain fiscally sound—incorporate client-centered usage of "new/per capita" funding;

* retain current staffing level and fill other vacancies as funding is available;

* purchase a site for a new main center and hold ground breaking; and

* continue efforts toward managed care by achieving Commission on Accreditation of Rehabilitation Facilities (CARF) accreditation.

Tri-County Community Mental Health Center
(Dillon, Chesterfield, and Marlboro Counties)

Computers have been a major focus again this year at Tri-County as we get ready for CARF accreditation and managed care. We have continued to upgrade our capacity to use the mainframe network in our outlying clinics and worked to increase the tasks that can be done by computer.

Tri-County Community Mental Health Center has seen an increase in its caseload this year going from approximately 1,300 to 1,500.

In Bennettsville, we have expanded to an adjacent building (Annex) to house the new employment and dual-diagnosis programs. Services for children have increased. All of our DSS slots have been filled.

We have opened a therapeutic nursery in Clio and are in the process of opening a second site in Cheraw.

We have continued to use some psychiatric help from Hall Institute, and we are installing a new tele-medicine hook-up to enhance consultation and assessment for Child, Adolescent, and Family Services.

In addition, we have formed an Elderly Services committee, and they are looking at ways to strengthen services. We have been emphasizing making links with all of our clients' health care providers and have especially focused on our elderly population.

The center has provided training on short-term therapy, and our therapists

are providing this service option on a regular basis. With that and some new screening processes, we have reduced the wait for an initial non-crisis assessment for adults to no more than two weeks.

We have continued to run our dual-diagnosis groups as well as several new groups for other special populations. Our doctors now rotate through an on-call system and can be paged for telephone back-up during hours when the Center is closed.

While we have had limited impact on our commitment rate, Tri-County has managed to reduce its use of state facility bed days by almost 3,000 days this year. This has been due to a more aggressive follow-up process for clients who are hospitalized.

This year the center has been very involved with intense interagency collaborative efforts. These include the Healthy Start initiatives, a new parenting center in Chesterfield County, and creating resource manuals for two counties. We also recently helped with an information fair for teachers on the first day of school.

The recent hiring of a staff member to oversee consultation and education as well as volunteers should increase our ability to collaborate with other agencies. She will also work with our consumer board to strengthen their input into center planning.

While our employment program has one staff member at this point, we have had success in this area during this first year of operation. The center now has six client employment slots, as well as one outside placement; two clients have moved on to VR, and several others have found their own jobs after training. We are providing weekly employment preparation seminars for interested clients.

We have not been as successful in creating new housing options, but we continue to help clients find already available housing and provide support for that move.

Goals for FY 96-97 are to:

* reduce center bed days to 25,200 by reducing the commitment rate to 238/100,000 or 19 per month and increasing treatment options by at least one—we are considering a modified partial hospitalization program, a drop-in center, and continuing to encourage local inpatient beds;
* complete the process for starting the tele-medicine program;
* obtain CARF accreditation;
* complete the Dillon building and break ground for the Chesterfield building; and
* continue to improve employment and housing options for our clients.

Waccamaw Center for Mental Health
(Georgetown, Horry, and Williamsburg counties)

Waccamaw Center for Mental Health continues to expand services to consumers who are priorities for DMH—the chronic mentally ill adult and the emotionally disturbed child.

We have also chosen to maintain a wide variety of services based on local needs. Continued expansion and flexibility in service delivery design are critical in our region which contains areas which have the second fastest growth rate in the nation. In contrast, parts of our catchment area are economically disadvantaged.

During the past year, staff numbers increased from 155 to 167. All additional staff are involved in direct service delivery. Training and staff development have focused upon group and short-term treatment methods, and services are designed to be provided where they are needed geographically.

Partnering with other agencies has increased. The School-Based program has 21 clinicians in three counties serving 20 schools. Contracts with local school boards and the USC Institute for Families in Society are part of this program.

In another area, an alliance has been formed with the three alcohol and drug commissions to work toward joint utilization of resources.

The center has an agreement with the local psychiatric hospital to provide short-term inpatient care for indigent consumers as an alternative to placement in a state facility, and our Crisis Stabilization Program is located in that building. In addition, the center provides internship placements for five academic institutions.

Outreach offices have been established in Little River and Loris in Horry County to make our services more accessible. Movement around Horry County has become a barrier to our consumers due to few roads and high traffic, so these offices are necessary, and they encourage relationships to develop with those communities.

Various grants continue in operation. They include a PATH Grant for the homeless mentally ill, a Family Intervention Services grant, and a Juvenile Justice grant in Williamsburg County. The Housing/Homeless program has enabled a local non-profit to obtain 23 units of housing on the old Myrtle Beach Air Base to be used as transitional housing for the homeless mentally ill, and an award has been received from DMH to renovate and start operations.

Estimated admissions for this fiscal year to April 1996 were 3,359, compared to 3,314 for the previous year. Fifty-nine percent of those admissions were seriously mentally ill adults, and approximately 28 percent were emotionally disturbed children. Waccamaw had 4,070 active cases in April 1996. Total contacts for the previous fiscal year were 86,452. The center operated within its budget with a small carry-over of funds.

During the coming year, the center will go through an accreditation process (CARF), and will move into the use of "levels of care" in the Utilization Review procedure in all clinics. All programs will be monitored for quality and fiscal

responsibility.

A priority continues to be the development of a new facility for the Georgetown Clinic, and a number of options are being considered to make this a reality.

Division of Inpatient Services

Bryan Hospital
(G. Werber Bryan Psychiatric Hospital)

The FY 95-96 year was a busy and productive one with 3,618 admissions and an average daily census of 198. In January, Bryan began to provide admission and pharmacy services to Morris Village and in June began providing admission services to Crafts-Farrow. The admissions area is outgrowing its space. Plans are under way to relocate the Medical Clinic to increase interviewing space.

A new director joined Bryan Hospital just in time for the HCFA survey in June. Bryan Hospital was found to be in compliance with both conditions of participation. Dr. Beverly Wood, the interim director for the majority of the fiscal year, provided the leadership needed in making the survey a success.

Lodge A is scheduled for completion in October. Plans are under way to renovate Lodge H. There will be some modifications based on what was learned from Lodge A. Since it will be considerable time before all lodges will be renovated, a "paint and patch" program was instituted. The last lodge is expected to be painted in August. The program has greatly improved the physical environment.

A portion of the residency program along with the Santee Wateree catchment area was reassigned to Bryan Hospital. Nursing, social work, and psychology are already hosting students. The residency program is a welcome addition.

The nursing department expanded a nursing position to meet the need for an improved nurse recruitment and retention program. A better organized hiring process resulted from this change.

The Volunteer Program provided 14,125 volunteer hours and received $133,464 in donations. The Volunteer Program runs the patient clothing store, holds parties for patients, and assures patients in the hospital over Christmas receive gifts and a special party. Since 1994, a volunteer program for youth has been in place. There were 10 youth volunteers in 1995. All benefited from the experience.

Goals for FY 96-97 are to:

* develop/enhance programs to meet the needs of the acutely ill psychiatric patient including the adult, older, and the dually diagnosed mentally ill/substance abuser and the mentally ill/mentally retarded; the patient whose symptoms are no longer acute and require a supervised placement other than long term inpatient; staff who will be providing the enhanced programming; and

students who are receiving training and education in psychiatry;

* collaborate with the community mental health centers and other providers to facilitate the return of patients to the least restrictive environment; and establish a network for managed care;

* develop criteria for determining staffing levels;

* decentralize Bryan's budgeting process by developing departmental budgets; and

* explore the development of new services for external customers, i.e., community mental health centers.

Byrnes Center
(James F. Byrnes Center for Geriatric Medicine, Education, and Research)

Byrnes Center is a 166-bed, JCAHO-accredited general hospital that has traditionally provided medical-surgical support for DMH's inpatient facilities.

While acute inpatient care remains an important focus, Byrnes' outpatient and ancillary services have expanded greatly in recent years as DMH has shifted toward a local care emphasis. Comparing FY 96 with FY 95, there was a 4 percent decrease in the total number of inpatient procedures/transactions, balanced by an increase in total outpatient procedures/transactions, and a 5 percent growth in Byrnes Clinic visits. Currently, approximately 33 percent of our budget and 31 percent of staffing complement are committed to outpatient/ ancillary activities.

Byrnes' vital role of providing the DMH community with expertise in clinical services, education and research was exemplified recently in the involvement of Byrnes staff/faculty in addressing regulatory concerns as well as direct patient care issues at Tucker/Dowdy Gardner.

Byrnes staff have also been involved in providing consultative support to the community, including Columbia CMHC's geropsychology program and the Lexington Alzheimer's Partnership—a day hospital program for demented clients and their families undertaken by Lexington CMHC and other agencies.

Major renovations of inpatient space at Byrnes were being completed in the summer 1996. These will allow for continued improvement of inpatient care and space for ongoing and planned innovative geriatrics programs. In addition, the new wards will be employed in accordance with approved DMH needs and program plans to maximize bed utilization, as appropriate, given environmental and resource considerations at Byrnes.

Byrnes enters the second year of its strategic planning process in 1996. We have met many of the objectives (others are ongoing) under last year's goals of providing quality care; enhancing care through education and professional development; and creating new knowledge on how to provide quality care.

We have successfully maintained our Acute Care for the Elderly program, which is currently being scientifically evaluated. An improved program planning process has been implemented, as have improved procedures for patient/ family education.

Our patient-care research activities have been boosted with the hiring of a

research department director.

Under the same general goals, subgoals, objectives, and action plans for FY 96-97 are being drafted and will be in place by the end of August 1996. Special planning emphasis will be placed on preparation for the July 1997 JHACO survey and implementation of Byrnes hospital committee restructuring.

Other objectives include provision of Byrnes' staff with improved information management and customer service skills, as well as the continued integration of research toward improvement of the quality, accessibility, and cost-effectiveness of care.

Division of Psychiatric Rehabilitation Services
(South Carolina State Hospital, Crafts-Farrow State Hospital, Intermediate Care Facility/Mental Retardation)

The facilities comprising the Division of Psychiatric Rehabilitation Services continued to consolidate during FY 95-96. A decision was made to transfer the patients and staff of Crafts-Farrow State Hospital to other facilities within the Department of Mental Health to avoid duplication of programs and to fully utilize staff resources.

Within these parameters, the long-term geriatric programs in Shand and Davis buildings were transferred to South Carolina State Hospital, and the McLendon Building Nursing Care Program was relocated to the C. M. Tucker/ Dowdy Gardner Nursing Care Center.

The acute admissions of geriatric patients to Crafts-Farrow State Hospital continued in Building #1, but as a result of Patrick B. Harris Psychiatric Hospital's accepting geriatric admissions for their catchment area and aggressive discharge planning, the closing of Ward 136 was accomplished. The remaining Ward 137 accepts both male and female geriatric admissions. Plans for relocating the Admissions Program to Bryan Psychiatric Hospital are in the final stages.

The consolidation at South Carolina State Hospital resulted in an increase in the census from 273 patients in July 1995, to 340 patients in July 1996. With the merger, a surplus list of employees was generated, and, with the support of the Department, all but 11 have been placed in positions at other hospitals or community mental health centers. We are continuing efforts to relocate these employees.

The Division has focused on the integration of the two hospitals' cultures with the goal of taking the best from each facility. Division committees provided the forum for the development of the mission and values statements, policies and procedures, study of Joint Commission on Accreditation of Healthcare Organizations functions and standards, and development of plans on the best way the facility can now comply with licensing and accreditation standards.

Also, the consolidation of the two facilities resulted in a need for staff education and training. For the first time since the mid-sixties, patients were not divided based solely on age. The level of care based on mental and physical needs determined which of the 11 wards patients would be assigned to at S. C.

State Hospital. A patient's age was not the determining factor in treatment or placement alternatives.

Clinical staff training was targeted for the awareness of special needs of patients with emphasis on the elderly. Staff was reassigned within the hospital environment to give them experience with different patient populations.

The Intermediate Care Facility/Mental Retardation Program, located on the Crafts-Farrow State Hospital campus, treats those patients diagnosed as having both a psychiatric problem and mental retardation. Within the Division, this program is a separate facility, certified/licensed by the Department of Health and Environmental Control for reimbursement by Health Care Finance Administration.

Training and placement of patients to group homes and community settings are a priority for the staff. The organization is developing plans to seek CARF accreditation for the coming year. The program has two wards with 50 patients, and there are no plans to relocate this program as they are separate from the consolidation efforts of Crafts-Farrow and S.C. State Hospital.

The consolidation and maintenance of division facilities was achieved without jeopardizing the JCAHO accreditation, HCFA certification, and DHEC certification licensing status.

Hall Institute
(William S. Hall Psychiatric Institute and USC School of Medicine Department of Neuropsychiatry and Behavioral Sciences)

General goals for FY 95-96 were to:

* maintain fiscal responsibility—in fact, the Institute ended the year with a modest surplus;

* continue the Total Quality Management process—the Institute has been reorganized into four divisions - Administration, Adult Services, Child and Adolescent Services and Forensic Services, forcing the interdisciplinary cooperation essential to the TQM process. Within various divisions, a number of TQM projects are ongoing. The composition of the Quality Council was revamped to place line and middle management individuals rather than upper management on the committee. This has been quite successful with a survey of personnel being completed and actions being instituted to respond to issues;

* prepare for Health Care Financing Administration (HCFA) survey—this was accomplished; the Institute currently meets both conditions. There was a special validation survey on June 18-21. We have been informed of the findings only informally; however, we expect no major problems except in the area of pharmacy services. This was a similar finding from our last Joint Commission survey. We have entered into a contract with Byrnes Medical Center which will address some of these problems and have taken steps to implement by October 1 the required patient profile on the wards;

* expand involvement in DMH activities—Dr. Jerrell has participated in the Public Health University Consortium and gathered data which is extremely useful in looking at the services provided by DMH across institutions and men-

tal health centers. Dr. Cuffe has acted as a consultant to Mr. Morris. Dr. Morgan has been actively involved with the interagency cooperation between DMH and DJJ. Dr. Pumariega accepted the responsibility for conducting the training for the individuals at the mental health centers who work with Child and Adolescent Services. Dr. Morgan has been actively involved in the cultural competency activities of the Department. Dr. Gruber has established a psychiatric rotation at Bryan Hospital and continues to work with the Santee-Wateree Mental Health Center;

* prepare for Managed Care—the director, deputy director, and associate directors meet on a daily basis to explore the possibilities of streamlining and thus preparing for managed care. On March 26, Gary Lang of Strategic Decision Systems from Atlanta specifically consulted with us on how the Institute should respond to managed care. We have kept abreast on activities in the DMH in its preparation for managed care. Our current assessment is that the Institute will not fair well in the managed care environment because of its primary mission of teaching and research as well as the fact that it can only be a provider rather than participate in any of the risk; and

* continue to build the Hall Institute infrastructure—this goal has not been achieved principally due to the physical constraints. We are continuing to attempt to maximize the productivity of those individuals who are currently employed in support goals.

Other accomplishments included:

* The General Residency matched all six positions in their first year training with highly qualified graduates of American medical schools. The curriculum was revised for the entire training program and the participation of the residents in the management team was established. A multi-disciplinary team headed by Dr. Larry Montgomery has worked with the architects to plan for the proposed new Forensic facility.

* Dr. Stathis is a participant in the Daniel X. Freedman Fellowship Program at the APA. Dr. Kenneth Rogers is a participant in the Faculty Scholars Program—UCLA.

Goals for FY 96-97 are to:

* recruit high quality trainees in the General Psychiatry, Child and Adolescent Psychiatry, and the Forensic Residency programs;

* respond to the Legislative Audit Council's recommendations;

* improve communication at all levels within the Institute;

* reduce contract costs by fully implementing Medicus, central staffing and personnel manager;

* complete competency requirements for all staff, effectively tie-in components with the hospital's total quality improvement programs to provide staff with goals and objectives that fit with the Institute's mission and vision; and

* obtain a satellite pharmacy program at the Institute, develop adequate patient medication profiles; move to daily cart exchanges for acute care units; and to improve the automated MAR system.

Harris Hospital
(Patrick B. Harris Psychiatric Hospital)

Harris Hospital, located in Anderson, successfully accomplished its mission of providing intensive, short-term, psychiatric diagnosis and treatment to the citizens who reached out for mental health care from the 14 counties of upstate South Carolina.

This inpatient facility provided emergency voluntary and involuntary psychiatric patient care for the adult and adolescent communities needing its services. Moreover, specialized programs for substance abuse disorders and the hearing impaired (state-wide) were also provided.

FY 95-96 was a most extraordinary year in the history of Harris Hospital. The highest level of JCAHO accreditation, Accreditation with Commendation, was maintained. HCFA surveyed the hospital and no deficiencies were cited for the third consecutive year. The hospital celebrated its Ten Year Anniversary with a gala event and recognized DMH and state officials for their positive support of Harris Hospital's mission and vision.

Barring some unforeseen event, the management team and staff look forward to FY 96-97 being one of the greatest, if not the greatest, year Harris Hospital has ever had.

During FY 95-96, a very dramatic metamorphosis began taking place in the hospital. The hospital culture has transitioned to where the management team and staff are more accepting of the demands being placed on them to maintain the hospital's position as a lean organization, a goal of every healthcare entity today that wants to survive within the managed care arena.

During this year many, if not most, of the clinical, administrative, and support staff broadened their skills, widened their knowledge, and recognized their abilities to flex and adapt to continually changing situations.

Harris Hospital encourages staff to perform "entrepreneurial public management," to cross disciplinary lines and work in teams. Staff were encouraged to exercise their abilities and intelligence to assess patient care, departmental or hospital-wide productivity and quality challenges, and address them appropriately.

Managers, supervisors, and the general staff have become more attuned to the public trust, accountability, and fiscal issues continuously confronting all healthcare organizations, including their own Harris Hospital.

Harris Hospital expanded its adult psychiatric age range from age 59 to include through-age 64, beginning in March of this fiscal year. This increase in patient population was absorbed into the adult psychiatric program without any additional money.

Moreover, Harris Hospital is positioning itself to add an additional program, a psycho-geriatric unit for patients aged 65 and over, to its present complement of programs (adult psychiatric, adolescent, substance abuse, and hearing impaired). The admission criteria has been finalized, and the psycho-geriatric program is scheduled to become operational during FY 96-97, tentatively August 1, 1996.

Accomplishments for FY 95-96 include:

* provided services to 2,552 patients including: adult psychiatric admissions, 1,957; adolescent admissions, 180; substance abuse admissions, 400; hearing impaired admissions, 15;

* enhanced the quality of care to its patients through continuous re-examination and improvement of the services provided—some of the improvements were achieved in concert with the Region B Mental Health Centers staff to ensure an integrated, community based system of patient care;

* provided through its Pharmacy Department economic prescription services (8,259 processed), consultant pharmacist services (104 hours) and patient/staff drug education services (52 hours) to the Region B community mental health centers in support of continuity of care;

* successfully recruited additional psychiatrists and other professional staff;

* enhanced the competence of clinical staff by providing opportunities to attend pertinent seminars and conferences;

* initiated community meetings resulting in improved communication between Harris Hospital's staff and management;

* ensured a cost-effective delivery of services through conscientious control of expenditures and through aggressive pursuit of initiatives that improve efficiency and reduce waste while not jeopardizing patient care; and

* strove to ensure that funding for capital expenditures required for improving and maintaining the hospital environment was received—this included, but was not limited to, acoustical treatment for the dining room and other patient areas, renovation of the pharmacy, roof repairs, etc.

Goals for FY 96-97 are to:

* actively recruit, develop and retain competent clinical, administrative, and support staff as appropriate;

* ensure that capital expenditures required for improving and maintaining the hospital environment and physical plant for patients and staff are an integral and significant part of the budget formulation and expenditure process by Harris Hospital in concert with the S.C. Department of Mental Health;

* collaborate across the hospital's divisions on a plan for continuing organizational improvement; and

* inform, support, and interact with the governing body to successfully attain the goals and objectives that have been established for the DMH.

FY 95-96 has seen challenging times for Harris Hospital. They have also been times of abounding opportunity, and Harris Hospital looks forward to FY 96-97 with great anticipation. However, no matter what kind of healthcare changes may confront Harris Hospital in the future, one fundamental thing is still certain and will never change. Harris Hospital pledges today as it has for more than 10 years, "to provide the best service it possibly can, with the resources it has, in as an efficient way as possible to meet the needs of the people it is privileged to serve."

Morris Village

(Earle E. Morris, Jr., Alcohol and Drug Addiction Treatment Center)

Goals for FY 95-96 included engaging in a long range strategic planning process; strengthening relationships with other DMH facilities and community referral sources; collaboration with DMH and Harris Psychiatric Hospital management regarding the possible transfer of that hospital's alcohol and drug treatment services to Morris Village; and collaborating with the South Carolina Department of Alcohol and Other Drug Abuse Services (DAODAS) and Hall Institute to explore the possibility of developing a "step down" or intensive outpatient unit for Morris Village.

Strategic Quality Planning:

The Morris Village Governing Body, through a SWOT (Strengths, Weaknesses, Opportunities, Threats) analysis, identified seven critical issues that must be managed by the facility. These are service delivery; staff training and development; information technology; managed care; treatment technology; marketing; and physical facility.

Each critical issue was then assigned to a team to develop strategies, goals, and objectives to address the specific issue. Teams have been meeting regularly since February, and final reports and recommendations are due in September. This process will better position Morris Village to respond proactively to the ever changing health care environment.

Strengthening Relationships with Other DMH Facilities and Community Referral Sources:

We continue to evaluate and improve accessibility of services for alcohol and drug patients being referred from other DMH facilities, particularly Bryan Psychiatric Hospital.

The waiting period from referral to admission has decreased dramatically, and the number of referrals has increased. Strategies to strengthen relationships with referral sources include a Quarterly Addiction Specialists Meeting which provides an opportunity for inpatient and community mental health center staff to communicate and problem solve.

Additionally, the community services coordinator continues to make regular visits to alcohol and drug abuse commissions and community mental health centers. Morris Village and DAODAS staff are working to develop a state level Memorandum of Agreement between DMH and DAODAS and are collaborating to develop a joint assessment that would be used by local alcohol and drug abuse commissions and Morris Village.

Transfer of Harris Hospital Alcohol and Drug Treatment Services to Morris Village:

This plan is presently on inactive status. Morris Village is open to further discussion when and if such discussions are deemed appropriate.

Development of a Step Down or Intensive Outpatient Unit for Morris Village:

The Morris Village Governing Body continues to work on development of a proposal for moving more intensive levels of care (Dual Diagnosis, Geriatric, Medical Detoxification) to Building One at Crafts-Farrow State Hospital. This

would then allow for establishing a lower level of care by licensing the cottages at Morris Village as residential care. These plans are in keeping with the national trend in substance abuse treatment to match patients with the appropriate level of care, minimizing the use of inpatient care for routine substance abuse treatment.

Goals for FY 96-97 are to:

* enhance Treatment Outcome Evaluation Process;

* continue development of the assessment protocol to be used by DAODAS and Morris Village;

* continue to evaluate treatment design to include lower levels of care. Continue the Strategic Quality Planning Process; and

* provide identified and requested training regarding issues of alcohol and other drug abuse treatment to community mental health center staff.

Our ultimate goal has been and will continue to be the strengthening of treatment services, thereby decreasing the negative impact of alcohol and other drug abuse on the citizens of South Carolina.

Division of Long Term Care Nursing Services

C. M. Tucker, Jr./Dowdy Gardner Nursing Care Center

C. M. Tucker, Jr./Dowdy Gardner Nursing Care Center continued to be responsive to their commitment of quality clinical services to its long-term residents. All organizational levels were active participants in the drive to improve resident care outcomes during the fiscal year.

Concrete examples for the year were:

* restraint reduction from 35 percent to less than 7 percent. This was done in collaboration with Byrnes Medical Center staff;

* opening of Fewell Pavilion which allowed the heavily skilled resident population to be cared for in one place—the nursing staff in that pavilion have become specialists in caring for this type of resident;

* a more home-like environment for residents was accomplished by adding wallpaper, matching bedspreads, and other decorative touches to each resident's room;

* Farmer campus had an outstanding DHEC survey;

* nurse practitioners are providing care for 88 residents in Fewell Pavilion;

* systems analysis by Abt consultants resulted in administrative changes to improve communication and accountability—new Administrator and Quality Management Division established;

* Quality Improvement team redesigned the Resident Care Assessment and Care Planning Conference process—this was piloted in Fewell Pavilion and continues to be implemented on Columbia campuses;

* successful VA survey for Stone Pavilion;

* Quality of Life interdisciplinary teams on each ward to improve daily activities for residents; and

* pilot project for "hiring" process, which reduced length of time from appli-

cation to first day of employment.

Richard Michael Campbell Veterans Nursing Home

* maintained licensure, certification, and VA requirements for all programs; and
* operated the facility within budget authorizations.

Dowdy Gardner Nursing Care Center/Rock Hill

* gradually phased out licensed beds through attrition;
* maintained licensure and certification for all programs; and
* operated within budget authorization.

Goals for FY 96-97 in Columbia are to:

* continue improving program services for residents manifesting psycho-behavioral problems;
* continue improving clinical and administrative processes through employee empowerment, quality improvement teams, and the principles of TQM;
* operate through the fiscal year within the budgetary allocations provided;
* implement budgets by cost centers;
* implement computerized acuity and staffing system;
* continue JCAHO accreditation; and
* maintain licensure and certification requirements.

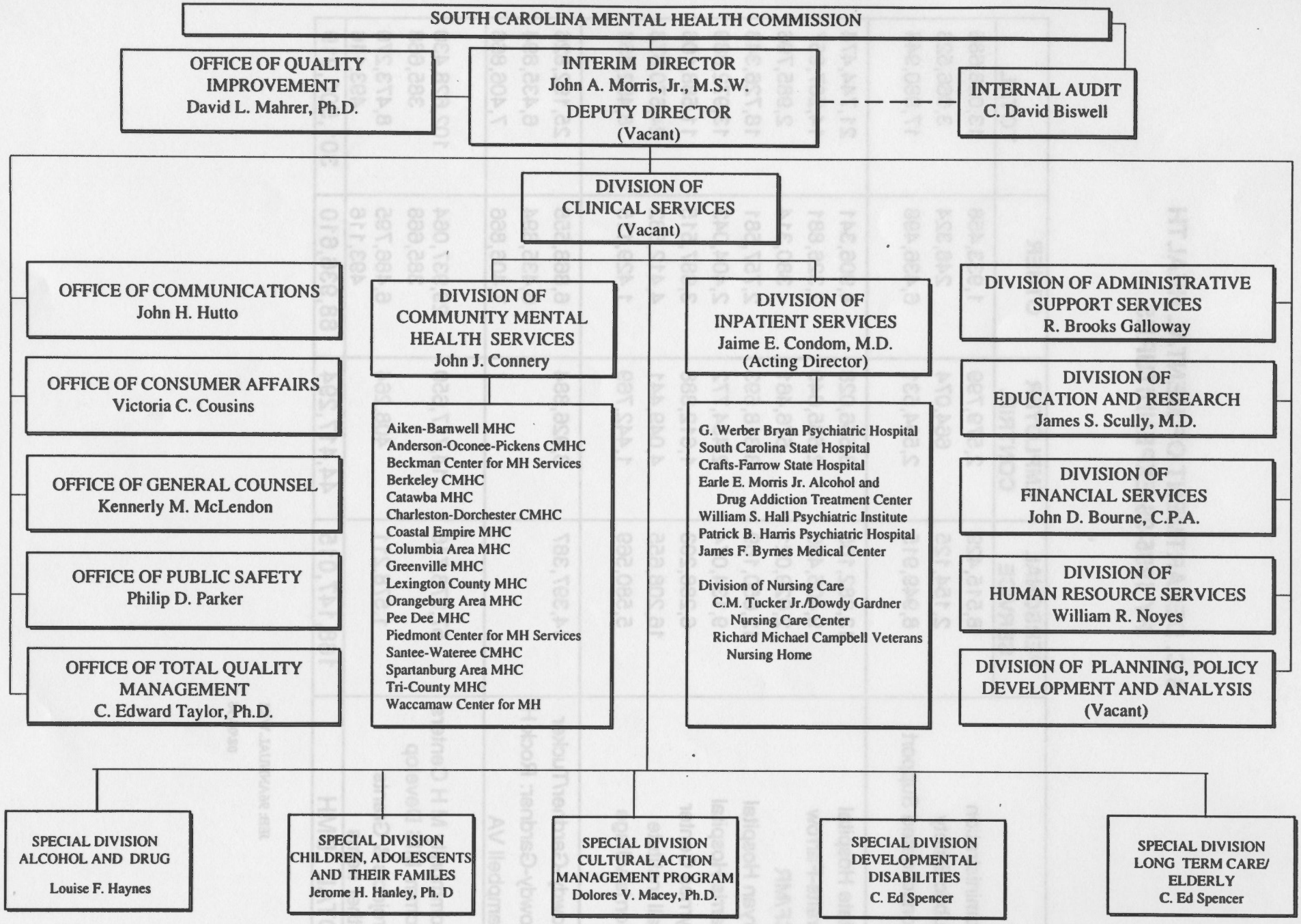
Richard Michael Campbell Veterans Nursing Home

* maintain licensure, certification, and VA requirements for all programs; and
* operate the facility within budget authorizations.

Dowdy Gardner Nursing Care Center/Rock Hill

* prepare to phase out remainder of licensed beds and place residents in appropriate long-term settings, as directed by the Mental Health Commission and SCDMH management.

S.C. DEPARTMENT OF MENTAL HEALTH



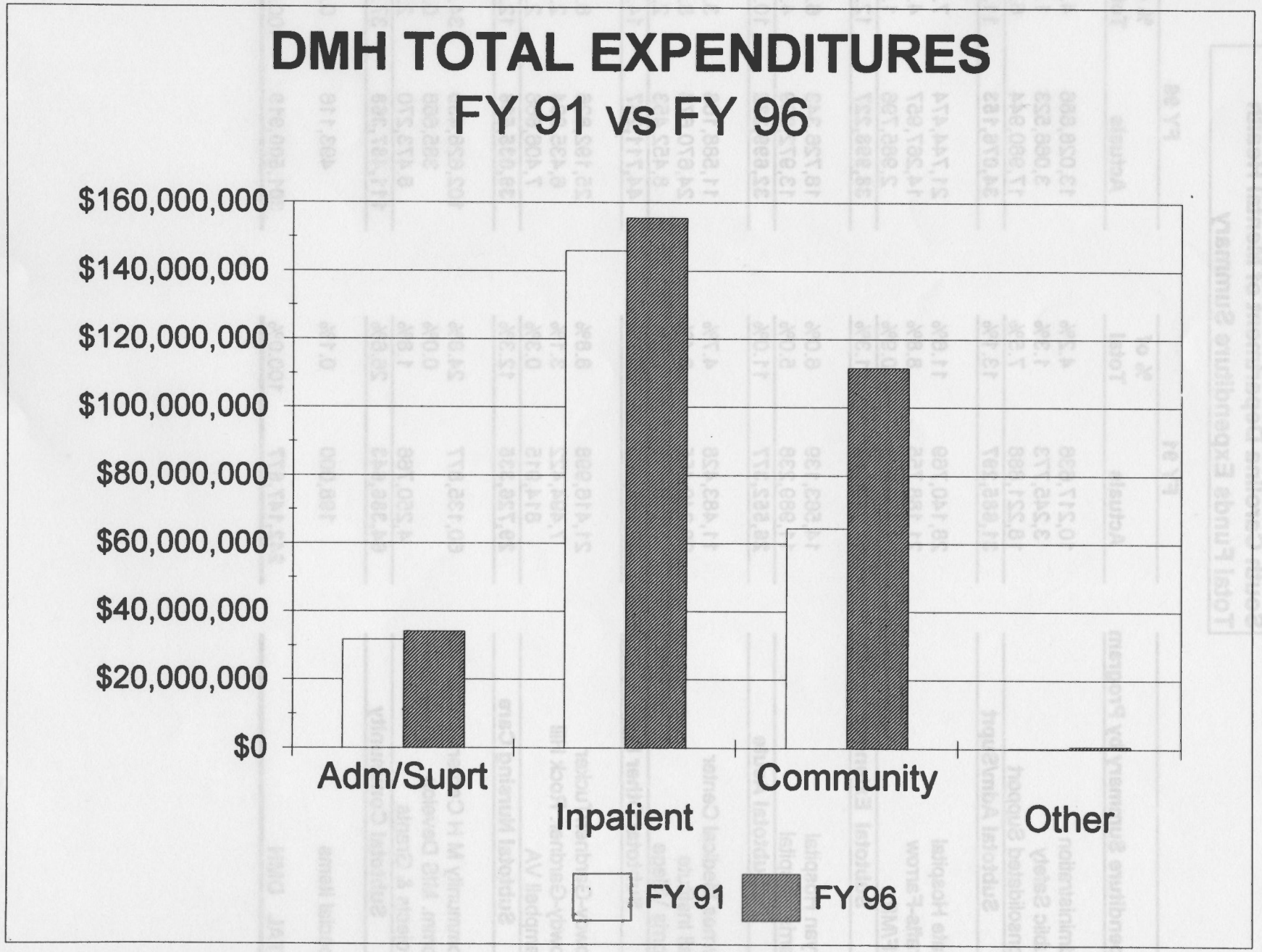
(approved by S.C. Mental Health Commission 9/10/96)

S.C. DEPARTMENT OF MENTAL HEALTH
FY 1995-96 EXPENDITURES

	PERSONAL SERVICE	EMPLOYER CONTRIB.	OTHER	TOTAL
Administration	8,515,429	2,579,799	1,933,458	13,028,686
Public Safety	2,154,125	664,074	248,324	3,066,523
Consolidated Support	8,949,915	2,594,531	6,436,498	17,980,944
State Hospital	13,282,105	3,556,028	4,906,341	21,744,474
Crafts-Farrow	9,405,436	2,535,640	2,326,881	14,267,957
ICF/MR	2,029,021	576,461	380,314	2,985,796
Bryan Hospital	12,650,169	3,318,593	2,757,581	18,726,343
Harris Hospital	9,134,074	2,434,772	2,404,043	13,972,889
Byrnes Center	6,288,203	1,612,388	3,687,515	11,588,106
Hall Institute	16,208,655	4,049,441	4,412,582	24,670,678
Morris Village	5,580,569	1,442,769	1,429,115	8,452,453
Dowdy-Gardner/Tucker	14,397,387	3,926,884	6,868,555	25,192,826
Dowdy-Gardner: Rock Hi			6,435,894	6,435,894
Campbell VA			7,406,866	7,406,866
Community M H Centers	57,973,716	14,717,650	29,937,064	102,628,430
Comm. MIS Develop			385,668	385,668
Projects & Grants	1,578,211	408,264	6,486,795	8,473,270
Other Items			493,116	493,116
TOTAL DMH	168,147,015	44,417,294	88,936,610	301,500,919

JEB: 96ANNUAL.WK1

08/05/96


DMH TOTAL EXPENDITURES
FY 91 vs FY 96
$160,000,000
$140,000,000
$120,000,000
$100,000,000
$80,000,000
$60,000,000
$40,000,000
$20,000,000
$0
Adm/Suprt
Inpatient
Community
Other
FY 91
FY 96

South Carolina Department of Mental Health
Total Funds Expenditure Summary

Expenditure Summary by Program	FY 91 Actuals	FY 91 % of Total	FY 96 Actuals	FY 96 % of Total
Administration	10,217,636	4.2%	13,028,686	4.3%
Public Safety	3,245,773	1.3%	3,066,523	1.0%
Consolidated Support	18,221,888	7.5%	17,980,944	6.0%
Subtotal Adm/Suprt	**31,685,297**	13.1%	**34,076,153**	11.3%
State Hospital	28,140,769	11.6%	21,744,474	7.2%
Crafts-Farrow	21,188,755	8.8%	14,267,957	4.7%
ICF/MR	2,300,029	0.9%	2,985,796	1.0%
Subtotal Extended	**51,629,553**	21.3%	**38,998,227**	12.9%
Bryan Hospital	14,563,139	6.0%	18,726,343	6.2%
Harris Hospital	11,989,238	5.0%	13,972,889	4.6%
Subtotal Acute	**26,552,377**	11.0%	**32,699,232**	10.8%
Byrnes Medical Center	11,483,428	4.7%	11,588,106	3.8%
Hall Institute	20,340,455	8.4%	24,670,678	8.2%
Morris Village	6,145,589	2.5%	8,452,453	2.8%
Subtotal Other Inpt	**37,969,472**	15.7%	**44,711,237**	14.8%
Dowdy-Gardner/Tucker	21,416,998	8.8%	25,192,826	8.4%
Dowdy-Gardner: Rock Hill	7,494,422	3.1%	6,435,894	2.1%
Campbell VA	814,915	0.3%	7,406,866	2.5%
Subtotal Nursing Care	**29,726,335**	12.3%	**39,035,586**	12.9%
Community M H Centers	60,135,877	24.8%	102,628,430	34.0%
Comm. MIS Develop		0.0%	385,668	0.1%
Projects & Grants	4,250,766	1.8%	8,473,270	2.8%
Subtotal Community	**64,386,643**	26.6%	**111,487,368**	37.0%
Special Items	198,000	0.1%	493,116	0.2%
TOTAL DMH	**242,147,677**	100.0%	**301,500,919**	100.0%

SOUTH CAROLINA DEPARTMENT OF MENTAL HEALTH
COMMUNITY MENTAL HEALTH SERVICES
FISCAL YEAR 1995-1996

CMHS	TOTAL ADMS	CLINICAL SERVICE ADMS	LIMITED CONTACT ADMS	TOTAL DSGS	CLINICAL ACTIVE CASES ON 6-30-96	TOTAL NUMBER SERVED
AIKEN	2,669	1,706	963	2,316	1,795	4,283
CATAWBA	2,854	2,023	831	2,604	2,126	4,841
COLUMBIA AREA	4,909	2,117	2,792	4,480	4,065	8,794
LEXINGTON	2,822	2,259	563	2,292	1,962	4,304
AND-OCON-PICK	5,344	4,459	885	5,103	4,456	9,712
BECKMAN	2,914	2,177	737	2,602	2,726	5,485
GREENVILLE	2,136	1,886	250	2,057	2,669	4,807
PIEDMONT	1,606	1,305	301	1,223	1,709	3,030
SPARTANBURG	3,047	2,442	605	2,977	3,768	6,862
PEE DEE	2,534	1,903	631	2,245	2,164	4,527
SANTEE-WATEREE	3,279	2,328	951	2,439	4,085	6,783
TRI-COUNTY	1,757	1,183	574	1,566	1,298	2,958
WACCAMAW	3,967	3,668	299	3,016	3,771	6,923
BERKELEY	1,895	1,648	247	1,722	1,448	3,183
CHASTN/DORCH	2,588	2,328	260	2,093	3,568	5,746
COASTAL EMPIRE	1,905	1,576	329	1,817	1,774	3,673
ORANGEBURG	1,766	1,729	37	1,751	2,006	3,772
TOTAL	47,992	36,737	11,255	42,303	45,390	89,683

REF: AR2MST00

Psychiatric Hospital Admissions Rates per 100,000 Population
Fiscal Year 1995 vs Fiscal Year 1996

	FY95	FY96		
	Rate	# of Adms	Rate	Variance
REGION A	**267.0**	**2,112**	**229.3**	**-37.6**
Aiken-Barnwell	142.0	274	171.7	29.7
Catawba	190.6	397	168.1	-22.5
Columbia Area	435.8	1,123	342.4	-93.4
Lexington	172.0	318	161.3	-10.6
REGION B	**206.4**	**2,349**	**193.2**	**-13.2**
Anderson-Oconee-Pickens	212.5	707	218.7	6.2
Beckman	249.6	419	183.9	-65.7
Greenville	198.7	371	203.8	5.1
Piedmont	153.6	243	151.0	-2.6
Greenville/Piedmont	2.4	82	23.9	21.5
Spartanburg	197.2	527	163.9	-33.4
REGION C	**210.1**	**1,676**	**215.1**	**5.0**
Pee Dee	236.7	479	211.4	-25.3
Santee-Wateree	198.7	439	213.5	14.8
Tri-County	289.0	278	278.9	-10.0
Waccamaw	166.4	480	194.2	27.8
REGION D	**77.1**	**552**	**65.9**	**-11.2**
Berkeley	64.9	82	57.0	-7.9
Charleston/Dorchester	56.0	178	46.1	-9.9
Coastal Empire	136.5	192	102.6	-33.9
Orangeburg	72.1	100	83.4	11.2
THE STATE	**192.2**	**6,726**	**179.2**	**-12.9**

SCDMH Psychiatric Admissions:

Includes all admissions to SCSH & Bryan; and includes CFSH after Feb. 1995
Includes adms to Harris on psych papers & adms to CFSH (thru Feb. 1995) on psych papers.
Includes the Children's Unit admissions at WSHPI.
The admission rates are annualized.
The variance is the difference between the FY 95 and FY 96 rates.
Population figures were used to calculate the admission rates.

REF: P1FY9596.WK3
DIRM, PDR
11 JUL 96
FILE CODE A-2

Psychiatric Readmission Rates to Psychiatric Hospitals
Fiscal Year 1995 vs Fiscal Year 1996

Community Mental Health Center	FY95 Rate	FY96 Adms	FY96 Rate	Variance
REGION A	**62.6**	**1,255**	**59.4**	**−3.2**
Aiken−Barnwell	48.2	134	48.9	0.7
Catawba	56.0	193	48.6	−7.3
Columbia Area	68.0	779	69.4	1.4
Lexington	58.3	149	46.9	−11.5
REGION B	**52.0**	**1,235**	**52.6**	**0.6**
Anderson−Oconee−Pickens	51.7	359	50.8	−0.9
Beckman	52.4	243	58.0	5.6
Greenville	59.4	225	60.6	1.3
Piedmont	55.8	131	53.9	−1.9
Greenville/Piedmont	62.5	45	54.9	−7.6
Spartanburg	46.1	232	44.0	−2.1
REGION C	**49.5**	**877**	**52.3**	**2.8**
Pee Dee	51.1	266	55.5	4.5
Santee−Wateree	46.6	222	50.6	4.0
Tri−County	55.7	174	62.6	6.9
Waccamaw	46.2	215	44.8	−1.4
REGION D	**53.8**	**296**	**53.6**	**−0.2**
Berkeley	44.4	36	43.9	−0.5
Charleston/Dorchester	60.2	102	57.3	−2.9
Coastal Empire	49.8	107	55.7	5.9
Orangeburg	59.3	51	51.0	−8.3
THE STATE	**55.1**	**3,685**	**54.8**	**−0.3**

SCDMH Psychiatric Admissions:
Includes all readmissions to SCSH, CFSH & Bryan.
Includes readmissions to Harris on psych papers.
Includes the Children's Unit readmissions at WSHPI.
Includes WSHPI readmissions to Ward 156 prior to 12−15−95.
The rate is the percentage of total psychiatric admissions that are readmissions.
The variance is the difference between the FY 95 and FY 96 rates.

REF: P7FY9596.WK3
DIRM, PDR
17 JUL 96
FILE CODE G

SOUTH CAROLINA DEPARTMENT OF MENTAL HEALTH

GENERAL STATISTICS

HOSPITAL SERVICES

FISCAL YEAR 1995-1996

TRANSACTIONS	MALE	FEMALE	TOTAL
RESIDENTS ON JULY 1, 1995	1230	908	2138
IN HOSPITAL	1170	872	2042
BMC/AREA HOSPITALS	23	14	37
ON LEAVE	0	0	0
ON PASS	37	22	59
FIRST ADMISSIONS	3019	2076	5095
READMISSIONS	3552	2000	5552
TOTAL ADMISSIONS	6571	4076	10647
TRANSFERS IN	177	175	352
RETURNS FROM EFF	61	16	77
RETURNS FROM EFP	7	6	13
TOTAL RECEIVED	6816	4273	11089
EFF'S	64	19	83
EFP'S	10	6	16
ADMINISTRATIVE DISCHARGES	14	4	18
REGULAR DISCHARGES	6416	4042	10458
DEATHS	139	78	217
TRANSFERS OUT	179	174	353
TOTAL SEPARATED	6822	4323	11145
STATISTICAL DISCHARGES	10	2	12
AVERAGE DAILY CENSUS	1192	871	2063
AVG LOS (IN DAYS) OF ALL RELEASES	75.3	112.0	89.6
RESIDENTS ON JUNE 30, 1996	1221	860	2081
IN HOSPITAL	1155	825	1980
BMC/AREA HOSPITALS	23	14	37
ON LEAVE	0	1	1
ON PASS	43	20	63

NOTE: Data for Directions (RTF at WSHPI) is included in Hospital Services.

Due to corrections and effective dates, figures may not add down.

Ref: ARIGENSTAT
DIRM, PDR

22 Aug 1996

SOUTH CAROLINA DEPARTMENT OF MENTAL HEALTH

GENERAL STATISTICS

PSYCHIATRIC HOSPITALS

FISCAL YEAR 1995-1996

TRANSACTIONS	MALE	FEMALE	TOTAL
RESIDENTS ON JULY 1, 1995	683	418	1101
IN HOSPITAL	638	390	1028
BMC/AREA HOSPITALS	10	8	18
ON LEAVE	0	0	0
ON PASS	35	20	55
FIRST ADMISSIONS	1953	1611	3564
READMISSIONS	2584	1596	4180
TOTAL ADMISSIONS	4537	3207	7744
TRANSFERS IN	141	127	268
RETURNS FROM EFF	42	9	51
RETURNS FROM EFP	7	6	13
TOTAL RECEIVED	4727	3349	8076
EFF'S	45	11	56
EFP'S	10	6	16
ADMINISTRATIVE DISCHARGES	2	1	3
REGULAR DISCHARGES	4564	3258	7822
DEATHS	20	6	26
TRANSFERS OUT	147	132	279
TOTAL SEPARATED	4788	3414	8202
STATISTICAL DISCHARGES	10	2	12
AVERAGE DAILY CENSUS	618	365	983
AVG LOS (IN DAYS) OF ALL RELEASES	68.9	73.0	70.6
RESIDENTS ON JUNE 30, 1996	620	354	974
IN HOSPITAL	569	333	902
BMC/AREA HOSPITALS	9	3	12
ON LEAVE	0	1	1
ON PASS	42	17	59

Due to corrections and effective dates, figures may not add down.

Ref: ARIGENSTAT
DIRM, PDR
22 Aug 1996

SOUTH CAROLINA DEPARTMENT OF MENTAL HEALTH
CHANGE IN HOSPITAL AVERAGE POPULATION
FY 90-91 TO FY 95-96

FACILITY	FY 91	FY 96	NBR CHANGE	PCT CHANGE
PSYCHIATRIC: Short-Term				
HPH	142	135	-07	-05%
BPH	182	198	16	09%
WSHPI	149	198	49	33%
	473	531	58	12%
Long-Term				
SCSH	516	290	-226	-44%
CFSH	496	162	-334	-67%
	1,012	452	-560	-55%
SPECIALTY:				
MV	158	139	-19	-12%
BMC	76	28	-48	-63%
	234	167	-67	-29%
NURSING:				
THRC	414	498	84	20%
DGNCC	496	215	-281	-57%
RMCVNH	61	215	154	252%
	971	928	-43	-5%
DMH TOTAL	2,690	2,078	-612	-23%

DIRM,PDR
REF: AR2
August 23, 1996

ADMISSIONS, DISCHARGES, IN-HOSPITAL CENSUS
FISCAL YEAR 1995-1996

FACILITY	ADMISSIONS/ TRANSFERS IN	REGULAR DISCHARGES	CENSUS JUNE 30	AVERAGE DAILY CENSUS
PSYCHIATRIC: Short-Term				
HPH	2,553	2,505	148	135
BPH	3,611	3,503	216	198
WSHPI	1,317	1,287	189	198
Long-Term				
SCSH	227	148	338	290
CFSH	304	379	83	162
SPECIALTY:				
MV	2,610	2,562	154	139
BMC	577	14	23	28
NURSING:				
THRC	210	15	517	498
DGNCC	79	21	209	215
RMCVNH	65	15	214	215
DIRECTIONS	23	23	13	13

DIRM,PDR
REF: AR1
August 23, 1996

SOUTH CAROLINA DEPARTMENT OF MENTAL HEALTH

GENERAL STATISTICS

G. WERBER BRYAN PSYCHIATRIC HOSPITAL

FISCAL YEAR 1995-1996

TRANSACTIONS	MALE	FEMALE	TOTAL
RESIDENTS ON JULY 1, 1995	141	70	211
IN HOSPITAL	137	69	206
BMC/AREA HOSPITALS	4	0	4
ON LEAVE	0	0	0
ON PASS	0	1	1
FIRST ADMISSIONS	782	665	1447
READMISSIONS	1375	785	2160
TOTAL ADMISSIONS	2157	1450	3607
TRANSFERS IN	3	1	4
RETURNS FROM EFF	7	0	7
RETURNS FROM EFP	0	0	0
TOTAL RECEIVED	2167	1451	3618
EFF'S	9	0	9
EFP'S	0	0	0
ADMINISTRATIVE DISCHARGES	0	0	0
REGULAR DISCHARGES	2109	1394	3503
DEATHS	4	1	5
TRANSFERS OUT	57	38	95
TOTAL SEPARATED	2179	1433	3612
STATISTICAL DISCHARGES	3	0	3
AVERAGE DAILY CENSUS	125	73	198
AVG LOS (IN DAYS) OF ALL RELEASES	22.0	18.6	20.7
RESIDENTS ON JUNE 30, 1996	129	87	216
IN HOSPITAL	124	84	208
BMC/AREA HOSPITALS	4	1	5
ON LEAVE	0	0	0
ON PASS	1	2	3

Due to corrections and effective dates, figures may not add down.

Ref: AR1GENSTAT
DIRM, PDR
22 Aug 1996

SOUTH CAROLINA DEPARTMENT OF MENTAL HEALTH

GENERAL STATISTICS

RICHARD M. CAMPBELL VETERANS NURSING HOME

FISCAL YEAR 1995-1996

TRANSACTIONS	MALE	FEMALE	TOTAL
RESIDENTS ON JULY 1, 1995	212	6	218
IN HOSPITAL	206	6	212
BMC/AREA HOSPITALS	4	0	4
ON LEAVE	0	0	0
ON PASS	2	0	2
FIRST ADMISSIONS	60	2	62
READMISSIONS	3	0	3
TOTAL ADMISSIONS	63	2	65
TRANSFERS IN	0	0	0
RETURNS FROM EFF	0	0	0
RETURNS FROM EFP	0	0	0
TOTAL RECEIVED	63	2	65
EFF'S	0	0	0
EFP'S	0	0	0
ADMINISTRATIVE DISCHARGES	0	0	0
REGULAR DISCHARGES	15	0	15
DEATHS	53	1	54
TRANSFERS OUT	0	0	0
TOTAL SEPARATED	68	1	69
STATISTICAL DISCHARGES	0	0	0
AVERAGE DAILY CENSUS	208	7	215
AVG LOS (IN DAYS) OF ALL RELEASES	578.0	779.0	580.9
RESIDENTS ON JUNE 30, 1996	207	7	214
IN HOSPITAL	205	7	212
BMC/AREA HOSPITALS	2	0	2
ON LEAVE	0	0	0
ON PASS	0	0	0

Due to corrections and effective dates, figures may not add down.

Ref: AR1GENSTAT
DIRM, PDR
22 Aug 1996

SOUTH CAROLINA DEPARTMENT OF MENTAL HEALTH

GENERAL STATISTICS

CRAFTS-FARROW STATE HOSPITAL

FISCAL YEAR 1995-1996

TRANSACTIONS	MALE	FEMALE	TOTAL
RESIDENTS ON JULY 1, 1995	139	172	311
IN HOSPITAL	133	157	290
BMC/AREA HOSPITALS	3	7	10
ON LEAVE	0	0	0
ON PASS	3	8	11
FIRST ADMISSIONS	84	67	151
READMISSIONS	71	72	143
TOTAL ADMISSIONS	155	139	294
TRANSFERS IN	8	2	10
RETURNS FROM EFF	2	1	3
RETURNS FROM EFP	1	4	5
TOTAL RECEIVED	166	146	312
EFF'S	2	1	3
EFP'S	1	4	5
ADMINISTRATIVE DISCHARGES	0	0	0
REGULAR DISCHARGES	197	182	379
DEATHS	8	3	11
TRANSFERS OUT	61	82	143
TOTAL SEPARATED	269	272	541
STATISTICAL DISCHARGES	0	0	0
AVERAGE DAILY CENSUS	71	91	162
AVG LOS (IN DAYS) OF ALL RELEASES	527.6	539.4	533.5
RESIDENTS ON JUNE 30, 1996	36	47	83
IN HOSPITAL	32	43	75
BMC/AREA HOSPITALS	0	2	2
ON LEAVE	0	0	0
ON PASS	4	2	6

Due to corrections and effective dates, figures may not add down.

Ref: ARIGENSTAT
DIRM, PDR
22 Aug 1996

SOUTH CAROLINA DEPARTMENT OF MENTAL HEALTH

GENERAL STATISTICS

DOWDY-GARDNER NURSING CARE CENTER

FISCAL YEAR 1995-1996

TRANSACTIONS	MALE	FEMALE	TOTAL
RESIDENTS ON JULY 1, 1995	64	177	241
IN HOSPITAL	63	176	239
BMC/AREA HOSPITALS	1	1	2
ON LEAVE	0	0	0
ON PASS	0	0	0
FIRST ADMISSIONS	1	1	2
READMISSIONS	27	23	50
TOTAL ADMISSIONS	28	24	52
TRANSFERS IN	14	13	27
RETURNS FROM EFF	0	0	0
RETURNS FROM EFP	0	0	0
TOTAL RECEIVED	42	37	79
EFF'S	0	0	0
EFP'S	0	0	0
ADMINISTRATIVE DISCHARGES	0	0	0
REGULAR DISCHARGES	1	20	21
DEATHS	10	22	32
TRANSFERS OUT	23	35	58
TOTAL SEPARATED	34	77	111
STATISTICAL DISCHARGES	0	0	0
AVERAGE DAILY CENSUS	65	150	215
AVG LOS (IN DAYS) OF ALL RELEASES	1463.1	1743.1	1657.4
RESIDENTS ON JUNE 30, 1996	72	137	209
IN HOSPITAL	71	135	206
BMC/AREA HOSPITALS	1	2	3
ON LEAVE	0	0	0
ON PASS	0	0	0

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DIRM, PDR
22 Aug 1996

SOUTH CAROLINA DEPARTMENT OF MENTAL HEALTH

GENERAL STATISTICS

WILLIAM S. HALL PSYCHIATRIC INSTITUTE

FISCAL YEAR 1995-1996

TRANSACTIONS	MALE	FEMALE	TOTAL
RESIDENTS ON JULY 1, 1995	137	42	179
IN HOSPITAL	116	40	156
BMC/AREA HOSPITALS	0	0	0
ON LEAVE	0	0	0
ON PASS	21	2	23
FIRST ADMISSIONS	477	293	770
READMISSIONS	346	198	544
TOTAL ADMISSIONS	823	491	1314
TRANSFERS IN	1	2	3
RETURNS FROM EFF	12	5	17
RETURNS FROM EFP	0	0	0
TOTAL RECEIVED	836	498	1334
EFF'S	11	5	16
EFP'S	0	0	0
ADMINISTRATIVE DISCHARGES	2	1	3
REGULAR DISCHARGES	791	496	1287
DEATHS	2	0	2
TRANSFERS OUT	14	2	16
TOTAL SEPARATED	820	504	1324
STATISTICAL DISCHARGES	0	0	0
AVERAGE DAILY CENSUS	152	46	198
AVG LOS (IN DAYS) OF ALL RELEASES	25.9	15.6	22.0
RESIDENTS ON JUNE 30, 1996	152	37	189
IN HOSPITAL	117	28	145
BMC/AREA HOSPITALS	0	0	0
ON LEAVE	0	0	0
ON PASS	35	9	44

Due to corrections and effective dates, figures may not add down.

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DIRM, PDR
22 Aug 1996

SOUTH CAROLINA DEPARTMENT OF MENTAL HEALTH

GENERAL STATISTICS

PATRICK B. HARRIS PSYCHIATRIC HOSPITAL

FISCAL YEAR 1995-1996

TRANSACTIONS	MALE	FEMALE	TOTAL
RESIDENTS ON JULY 1, 1995	71	57	128
IN HOSPITAL	68	57	125
BMC/AREA HOSPITALS	1	0	1
ON LEAVE	0	0	0
ON PASS	2	0	2
FIRST ADMISSIONS	608	585	1193
READMISSIONS	791	541	1332
TOTAL ADMISSIONS	1399	1126	2525
TRANSFERS IN	22	6	28
RETURNS FROM EFF	4	1	5
RETURNS FROM EFP	3	0	3
TOTAL RECEIVED	1428	1133	2561
EFF'S	6	3	9
EFP'S	4	0	4
ADMINISTRATIVE DISCHARGES	0	0	0
REGULAR DISCHARGES	1389	1116	2505
DEATHS	0	0	0
TRANSFERS OUT	12	10	22
TOTAL SEPARATED	1411	1129	2540
STATISTICAL DISCHARGES	6	2	8
AVERAGE DAILY CENSUS	74	61	135
AVG LOS (IN DAYS) OF ALL RELEASES	18.9	19.3	19.1
RESIDENTS ON JUNE 30, 1996	87	61	148
IN HOSPITAL	85	61	146
BMC/AREA HOSPITALS	2	0	2
ON LEAVE	0	0	0
ON PASS	0	0	0

Due to corrections and effective dates, figures may not add down.

Ref: AR1GENSTAT
DIRM, PDR
22 Aug 1996

SOUTH CAROLINA DEPARTMENT OF MENTAL HEALTH

GENERAL STATISTICS

EARLE E. MORRIS, JR. ALCOHOL AND DRUG TREATMENT CENTER

FISCAL YEAR 1995-1996

TRANSACTIONS	MALE	FEMALE	TOTAL
RESIDENTS ON JULY 1, 1995	87	37	124
IN HOSPITAL	87	37	124
BMC/AREA HOSPITALS	0	0	0
ON LEAVE	0	0	0
ON PASS	0	0	0
FIRST ADMISSIONS	989	454	1443
READMISSIONS	865	302	1167
TOTAL ADMISSIONS	1854	756	2610
TRANSFERS IN	0	0	0
RETURNS FROM EFF	19	7	26
RETURNS FROM EFP	0	0	0
TOTAL RECEIVED	1873	763	2636
EFF'S	19	8	27
EFP'S	0	0	0
ADMINISTRATIVE DISCHARGES	12	3	15
REGULAR DISCHARGES	1817	745	2562
DEATHS	2	0	2
TRANSFERS OUT	0	0	0
TOTAL SEPARATED	1850	756	2606
STATISTICAL DISCHARGES	0	0	0
AVERAGE DAILY CENSUS	98	41	139
AVG LOS (IN DAYS) OF ALL RELEASES	19.2	19.7	19.4
RESIDENTS ON JUNE 30, 1996	110	44	154
IN HOSPITAL	108	43	151
BMC/AREA HOSPITALS	2	1	3
ON LEAVE	0	0	0
ON PASS	0	0	0

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DIRM, PDR
22 Aug 1996

SOUTH CAROLINA DEPARTMENT OF MENTAL HEALTH

GENERAL STATISTICS

SOUTH CAROLINA STATE HOSPITAL

FISCAL YEAR 1995-1996

TRANSACTIONS	MALE	FEMALE	TOTAL
RESIDENTS ON JULY 1, 1995	195	77	272
IN HOSPITAL	184	67	251
BMC/AREA HOSPITALS	2	1	3
ON LEAVE	0	0	0
ON PASS	9	9	18
FIRST ADMISSIONS	2	1	3
READMISSIONS	1	0	1
TOTAL ADMISSIONS	3	1	4
TRANSFERS IN	107	116	223
RETURNS FROM EFF	17	2	19
RETURNS FROM EFP	3	2	5
TOTAL RECEIVED	130	121	251
EFF'S	17	2	19
EFP'S	5	2	7
ADMINISTRATIVE DISCHARGES	0	0	0
REGULAR DISCHARGES	78	70	148
DEATHS	6	2	8
TRANSFERS OUT	3	0	3
TOTAL SEPARATED	109	76	185
STATISTICAL DISCHARGES	1	0	1
AVERAGE DAILY CENSUS	196	94	290
AVG LOS (IN DAYS) OF ALL RELEASES	1043.5	661.5	870.5
RESIDENTS ON JUNE 30, 1996	216	122	338
IN HOSPITAL	211	117	328
BMC/AREA HOSPITALS	3	0	3
ON LEAVE	0	1	1
ON PASS	2	4	6

Due to corrections and effective dates, figures may not add down.

Ref: ARIGENSTAT
DIRM, PDR
22 Aug 1996

SOUTH CAROLINA DEPARTMENT OF MENTAL HEALTH

GENERAL STATISTICS

C. M. TUCKER, JR. HUMAN RESOURCES CENTER

FISCAL YEAR 1995-1996

TRANSACTIONS	MALE	FEMALE	TOTAL
RESIDENTS ON JULY 1, 1995	178	263	441
IN HOSPITAL	170	256	426
BMC/AREA HOSPITALS	8	5	13
ON LEAVE	0	0	0
ON PASS	0	2	2
FIRST ADMISSIONS	16	3	19
READMISSIONS	67	67	134
TOTAL ADMISSIONS	83	70	153
TRANSFERS IN	22	35	57
RETURNS FROM EFF	0	0	0
RETURNS FROM EFP	0	0	0
TOTAL RECEIVED	105	105	210
EFF'S	0	0	0
EFP'S	0	0	0
ADMINISTRATIVE DISCHARGES	0	0	0
REGULAR DISCHARGES	10	5	15
DEATHS	54	49	103
TRANSFERS OUT	9	7	16
TOTAL SEPARATED	73	61	134
STATISTICAL DISCHARGES	0	0	0
AVERAGE DAILY CENSUS	200	298	498
AVG LOS (IN DAYS) OF ALL RELEASES	761.8	1332.2	1021.4
RESIDENTS ON JUNE 30, 1996	209	308	517
IN HOSPITAL	200	298	498
BMC/AREA HOSPITALS	9	8	17
ON LEAVE	0	0	0
ON PASS	0	2	2

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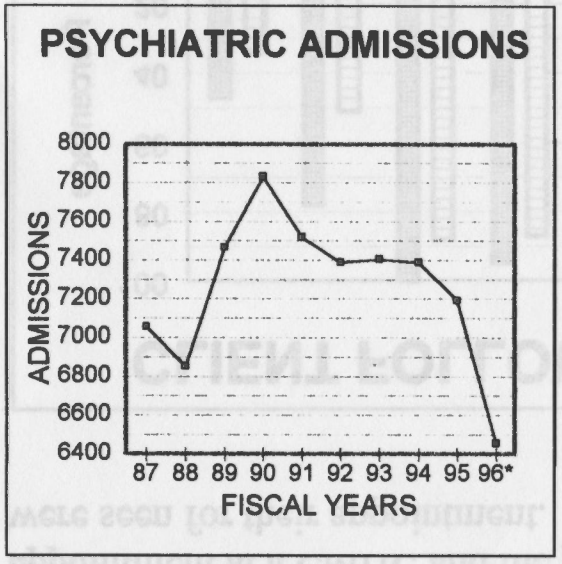
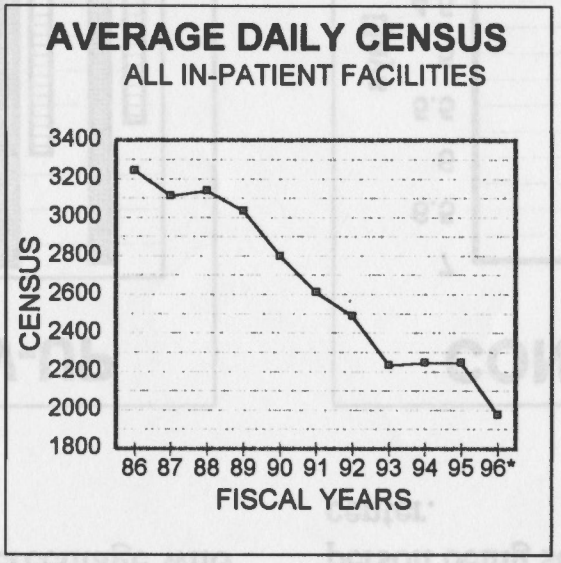
Ref: AR1GENSTAT
DIRM, PDR
22 Aug 1996

DEVELOPMENT OF A COMMUNITY-BASED SYSTEM

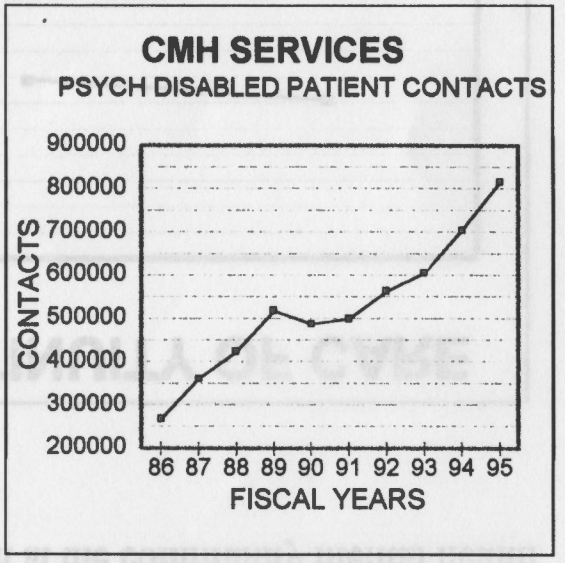
Our agency priority is to serve people in their home communities. A strong community mental health system is reflected by less reliance on in-patient facilities and a growth in services at the local level.



* Estimated, as of February, 1996



* Estimated, as of February, 1996

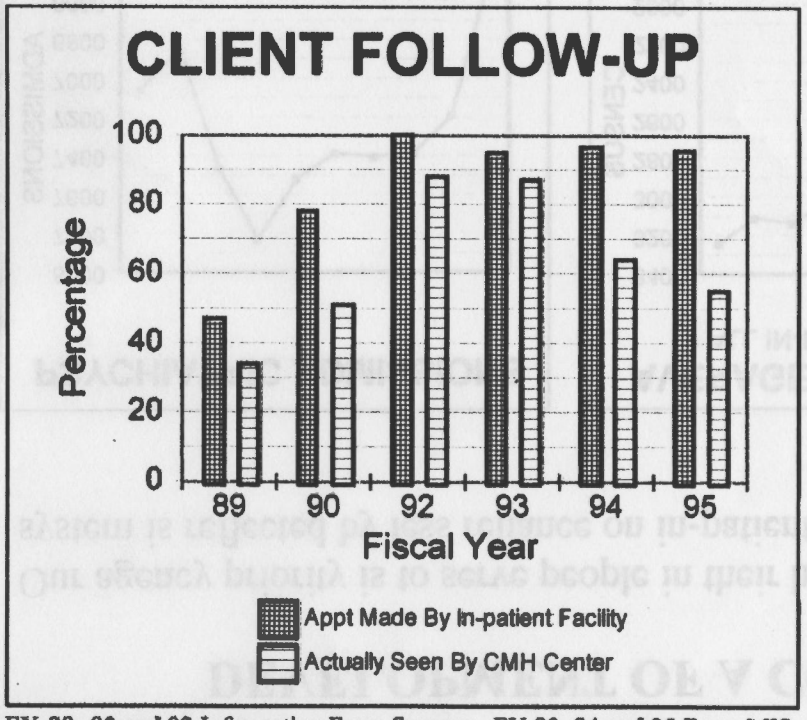


For Detail Information on These Data, Contact the Division of Planning

CONTINUITY OF CARE

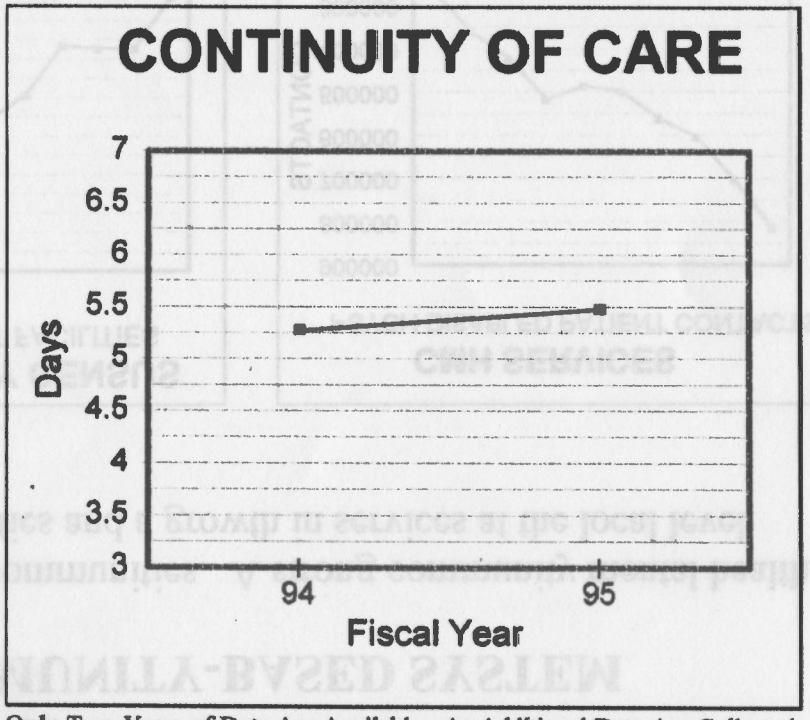
When consumers of mental health services are discharged from an in-patient facility, they are best served if seen by their local mental health center as soon as possible after they are discharged.

The chart below shows the percentage of people discharged from in-patient facilities with an appointment at a CMHC and the percentage who were seen for their appointment.



FY 89, 90 and 92 Information From Surveys. FY 93, 94 and 95 From MIS.
FY 91 Information Not Available.
For Detail Information on These Data, Contact the Division of Clinical Services.

The chart below shows the length of time between discharge from an in-patient facility and the person being seen at the community mental health center.

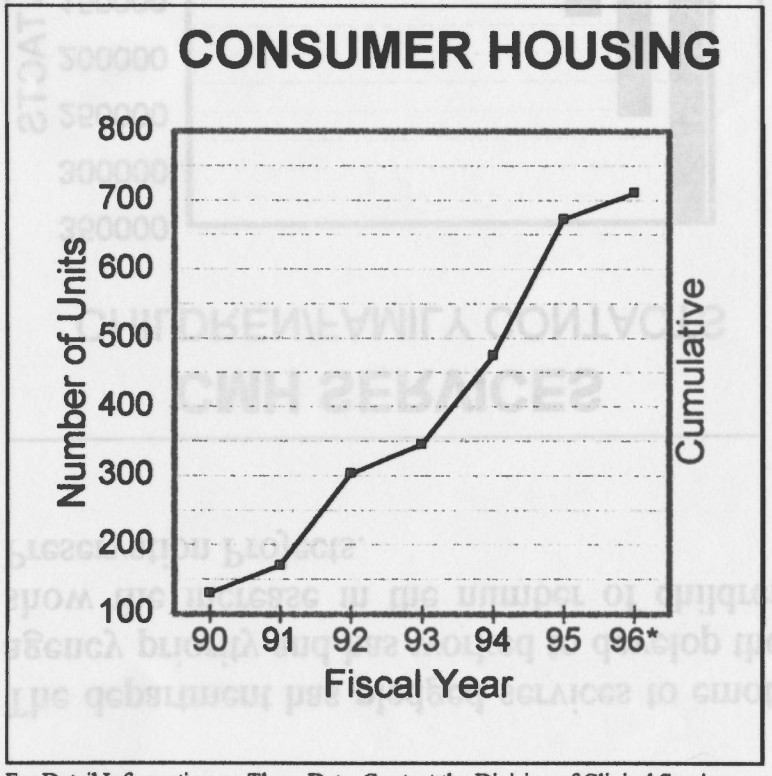


Only Two Years of Data Are Available. As Additional Data Are Collected, They Will Be Added To This Important Measurement.
For Detail Information on These Data, Contact the Division of Clinical Services

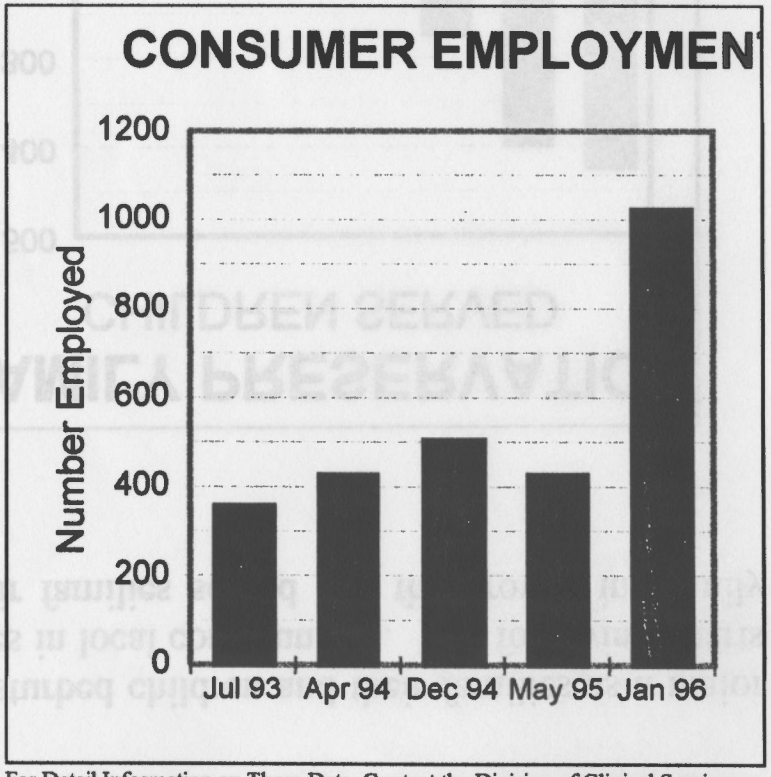
QUALITY OF LIFE MEASURES

We are committed to assisting people with mental illness to improve the quality of their lives through meaningful employment and access to independent living arrangements in the most normal environment possible.

The following charts show the development of residential opportunities and department-assisted employment for consumers.



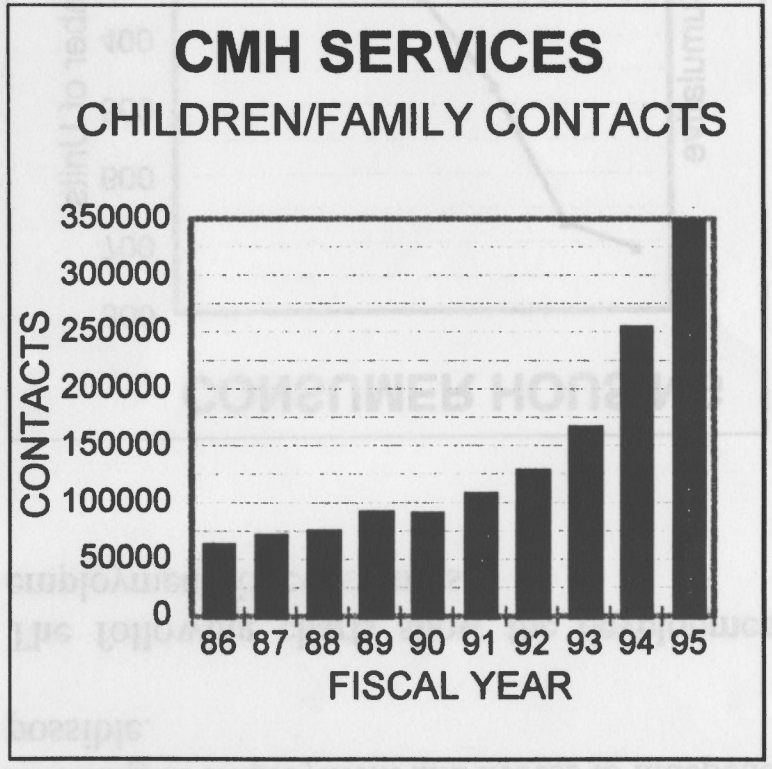
For Detail Information on These Data, Contact the Division of Clinical Services
* As of February, 1996

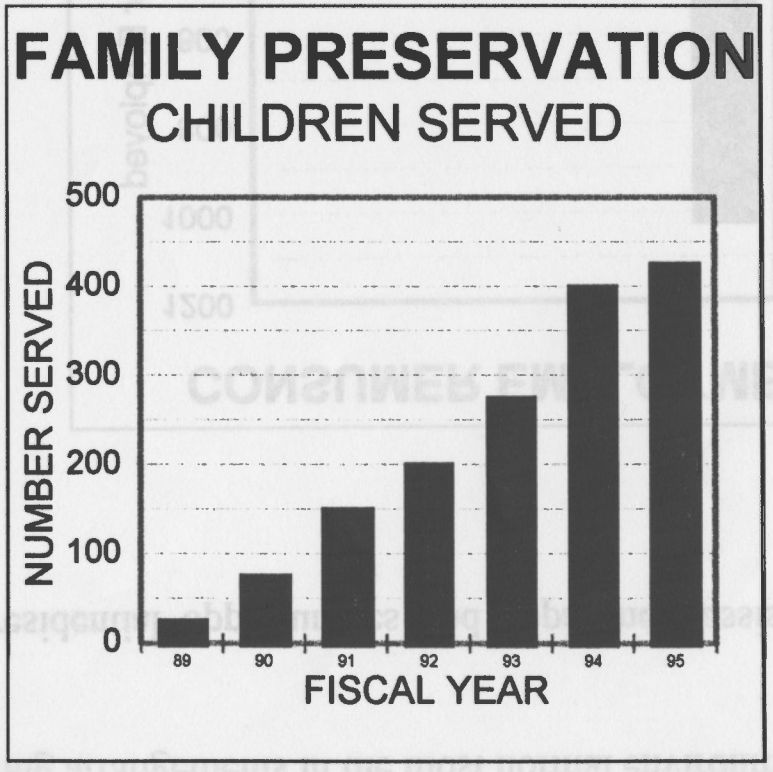


For Detail Information on These Data, Contact the Division of Clinical Services

SERVICES TO CHILDREN, ADOLESCENTS AND THEIR FAMILIES

The department has pledged services to emotionally disturbed children and their families as a major agency priority and has worked to develop these services in local communities. The following charts show the increase in the number of children and their families served and the growth in Family Preservation Projects.



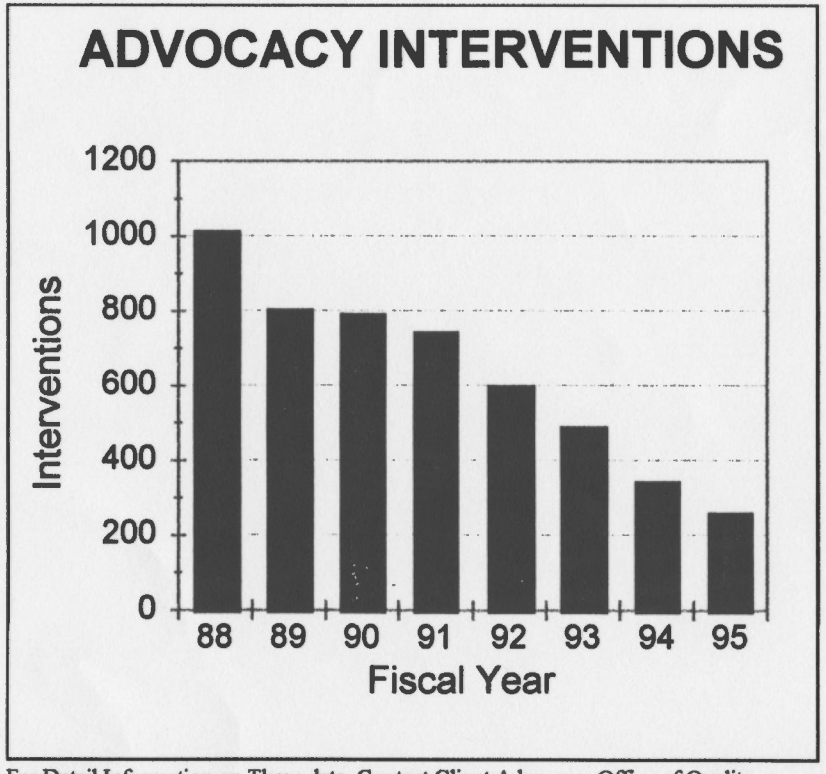


For Detail Information on These Data, Contact the Division of Children, Adolescents and Their Families

CONSUMER/FAMILY COMPLAINTS

Providing quality services to consumers and their family members means responding to their needs. One indication of the degree with which the department improves its services is by monitoring the number of complaints that are received by its internal advocates who intervene on behalf of the patient or family member to resolve concerns.

The following chart tracks the number of interventions requested of client advocacy in our in-patient facilities.



For Detail Information on These data, Contact Client Advocacy, Office of Quality Improvement

$628.50	Total Printing Cost
300	Total Number of Units Printed
2.09	Cost Per Unit

SC Dept of Mental Health